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SUMMARY OF LECTURES

AT THE

CAMBRIDGE SUMMER SCHOOL

5th—19th JULY, 1947

Organised by the
WOMEN PUBLIC HEALTH OFFICERS' ASSOCIATION
5, VICTORIA STREET, LONDON, S.W.1.

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A HEALTHY FAMILY—A HEALTHY NATION

The Summer School of Women Public Health Officers held in Cambridge in July, 1947, opened with a very interesting address of welcome, by His Worship the Mayor of Cambridge, Councillor F. Doggett. He said he saw that the theme was to be 'A Healthy Family—a Healthy Nation', and he agreed that if individual families were healthy in mind and body, then the outlook of the nation as a whole would be clean and healthy. The Women Public Health Officers, through their close association with the family and its problems, have, as a body, a very important task in helping to build a healthy nation.

He was very proud that Cambridge had been chosen as the seat for the Summer School, and he felt that the City was not lacking in interest either from the Public Health, Education or Cultural points of view. He hoped they would take full advantage of the facilities open to them, and would enjoy their brief stay in the City.

The Mayor was introduced by the Chairman, Sir Lionel Whitby, C.V.O., M.C., F.R.C.P., Regius Professor of Physic.

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PROGRAMME

"A HEALTHY FAMILY—A HEALTHY NATION"

Opening Session:

CHAIRMAN: SIR LIONEL WHITBY, C.B.O., M.C., F.R.C.P., Regius Professor of Physic.

Address of Welcome by His Worship the Mayor of Cambridge, Councillor F. DOGGETT.

Inaugural Lecture. "The National Health Service."

A. LESLIE BANKS, M.A., M.D., M.R.C.P., D.P.H., Barrister-at-Law; Senior Medical Officer, Ministry of Health.

A.—GROWING UP.

"The Health Problems of Growing Up."

J. D. KERSHAW, M.D., B.S., D.P.H., Medical Officer of Health and School Medical Officer, Borough of Colchester.

"After-Care Work."

MISS G. Y. MILLER, County Juvenile Employment Officer, Cambridgeshire Education Committee.

"The Maladjusted Child."

R. G. E. RICHMOND, M.R.C.S., L.R.C.P., Fellow of the Philosophical Society of England, Medical Inspector, Children's Branch, Home Office.

"Health of the School Leaver."

H. SMITH, M.R.C.S., L.R.C.P., D.P.Y., Principal Assistant Medical Officer, London County Council.

"School Meals."

MISS ELIZABETH MASON, B.Sc., M.A., formerly Senior Dietitian to the Ministry of Food.

B.—A HAPPY HOME LIFE

"Preparation for Marriage."

DAVID R. MACE, M.A., B.Sc., Ph.D., Secretary, National Marriage Guidance Council.

"Budgeting for the Family."

JOHN STAMPS, Deputy Secretary, Family Welfare Association.

"Adoption."

D. H. GEFFEN, M.D., D.P.H., Medical Officer of Health, Metropolitan Borough of Saint Pancras.

"Talks and Demonstration on Discussion Technique."

Demonstration discussion Groups.

"Can Housewives Afford Leisure Time?"

MISS B. POWLETT, B.A. (Cambridge) and GORDON WHITELAW, B.A., Training Officers, The Bureau of Current Affairs.

"Care of the Aged and Infirm."

THE RIGHT HON. LORD AMULREE, M.D., F.R.C.P.

"Mending Broken Homes."

MRS. E. WATSON, M.A., Honorary Secretary, The Elizabeth Fry Centenary Fund.

C.—THE YOUNG FAMILY

"Ante-Natal Care."

MISS GLADYS HILL, M.D., F.R.C.S., F.R.C.O.G., Obstetric Surgeon, Royal Free Hospital.

"Infant Feeding."

D. MCCARTHY, M.D., M.R.C.P., D.C.H., Assistant to the Professor of Child Health, British Post Graduate Medical School, University of London.

"The Young Child."

MISS K. DAVEY, Montessori Diploma, Nursery School Diploma, M.R.S.T., Head Teacher, Lancasterian Infant's Nursery School, Tottenham.

"Public Health Care of Spastic Children."

J. L. BURN, M.D., D.Hy., D.P.H., Medical Officer of Health and School Medical Officer, Borough of Salford.

"Making the Crooked Straight."

MISS L. BILLINGHURST, Diploma of the Orthoptic Board, Lecturer at the Royal Westminster Ophthalmic Hospital School of Orthoptics.

D.—GENERAL.

"Social Implications of Tuberculosis, with special reference to the New Health Act."

AIR-COMMODORE R. R. TRAIL, M.C., M.D., F.R.C.P., Medical Director, Papworth Village Settlement.

"The Value of Health Visitor's Records."

MISS H. S. COOPER HODGSON, M.B.E., formerly Superintendent Health Visitor, County Durham.

"Good Dentition."

WILLIAM RITCHIE YOUNG, L.D.S., R.F.P.S.G., Assistant Consulting Dental Surgeon, London County Council.

"The Art of Teaching." (two sessions).

PROFESSOR J. W. TIBBLE, M.A., M.Ed., Department of Education, University College, Leicester.

Concluding Lecture:

"The Building of Family Life—The Common Task."

MISS LETITIA FAIRFIELD, C.B.E., M.D., D.P.H., Barrister-at-Law.

Inaugural Lecture

THE NATIONAL HEALTH SERVICE

Dr. A. Leslie Banks.

Before the N.H.S. can be considered in detail, it will be necessary to consider other measures of social legislation with which it is linked, as a number of statutes recently passed, interlock in their relationship to the health services of the country. In particular, the Education Act, 1944, the National Insurance Act, and the National Health Service Act, have the provision of a comprehensive medical service for the whole nation as a common denominator.

Sect. 48 of the Education Act, makes it the duty of every Local Authority to ensure comprehensive facilities for free medical treatment of school children, and this range of treatment joins with that other comprehensive service to be provided under the National Health Service. The picture is not yet complete, and the full extent of social legislation will not be known untl the Bill abolishing Poor Law, and establishing a system of National Assistance is introduced.

Naturally the greatest effect on hospital and health services is produced by the N.H.S. Act. This provides for a comprehensive health service for England and Wales.

Part I deals with central administration, including the formation of a Central H.S. Council to advise the Minister.

Part II deals with hospital and specialist services.

Part III deals with health services provided by the Local Health Authorities, those being the County, and County Borough Councils.

Part IV is concerned with general medical, dental, pharmaceutical, and supplementary ophthalmic services.

Part V makes special provision as to Mental Health Services.

That is the broad structure of the Act, and it is the essence of it that the various branches dealt with are co-ordinated to form one service, with the Minister of Health answerable to Parliament for the whole. The local administration of hospital and specialist services is to fall upon Regional Hospital Boards, which will in turn work through the local Hospital Mangagement Committees. By this means, it will be possible to retain a great deal of the local interest, which is such a characteristic feature of our hospital services.

There are 14 hospital regions, 4 of which deal with London and the home counties, and the remaining 10 the rest of England and Wales. Linked with each Regional hospital Board will be the teaching hospital of the parent university thereby ensuring that the influence of University teaching and research is spread throughout the region. Power has been taken in the Act, to continue the wartime Public Health Laboratory and the Blood Transfusion Services in a permanent form.

The administration of domiciliary medical and dental services will be the responsibility of specially constituted Executive Councils. The area covered by each Executive Council corresponds broadly with that of the County or County Borough in which it is situated, but in some areas, it has been found convenient to set up one Executive Council to deal with the County Borough and adjoining county. It is clearly necessary to ensure that the work of the Executive Council is closely linked with the Regional Hospital Board, and the latter are required to consult the former before setting up the Hospital Management Committee in any area.

Part III of the N.H.S. Act deals with the duties of the new Local Health Authorities, these being the County and County Borough Councils. Sects. 19-30 deal inter alia with the provision of a midwifery service, care of mothers and young children, health visiting, home nursing, immunisation services, ambulance services and health centres. These are duties laid on the L.H.A. with one end in view. The L.H.A. is made responsible for a service for the care of people in their homes, supplementary to the clinical care provided by the G.P.'s and the hospitals. For domiciliary midwifery it is proposed to organise a team in each area under the general supervision of the hospital obstetric consultant. That team will consist of domiciliary midwives and G.P.'s with special experience in midwifery. It will also incorporate the appropriate M.O.'s of the present L.A. maternity service.

The L.H.A. must also arrange for the general care of expectant mothers and of children under 5. There are two important factors in relation to this:—

1. Is the need to ensure continuity of medical care for both mother and child.
2. Concerns the continuity of medical records, extending through school and later into adult life.

Sect. 24. deals with H.V.'s who are to give advice on the care of expectant and nursing mothers, young children, and persons suffering from illness, and also on the measures necessary to prevent spread of infection. This definition of a H.V.'s duties has given rise to some misunderstanding. The "giving advice to persons suffering from illness" has been interpreted as an infringement of the duty of G.P. This is not the case, e.g. A household with mother in an advanced state of pregnancy, one young child with W.Cough and possibly early bronchopneumonia, and as so often happens, an elderly and somewhat senile relative in the background, will provide ample scope for the H.V. working in conjunction with the G.P. She will be needed to advise the mother, to arrange for home-help, to see to the proper care of the children, and advise on the best way to deal with the aged relative.

Side by side with the H.V.'s responsibilities is the organisation of a home nursing service.

Sect. 25. lays down that "It shall be the duty of every L.A. to make provision in their area for securing the attendance of nurses on persons who require nursing in their own towns."

The growth of D.N.A.'s and the great reputation built up in the last 60-70 years by the D.N.s needs no emphasis, but the existing D.N. service shows great gaps. Highly organised D.N.A.'s adjoin small and impoverished associations employing one or two nurses. Other areas many be entirely uncovered by the D.N.A.'s. L.H.A.'s must be free to build up the service which they think is best fitted to their own area, but it is clear that they will need to make full use of the existing organisations, and a review of their resources will show where financial support is necessary, additional equipment required, and where adequate transport on which the D.N. depends, has to be provided. Arrangements will have to be made to ensure that the G.P. can call on the District Nurse without delay. The D.N. Superintendent will need to be in close touch with the H.V.'s and district midwives. In time there may be one superintendent for all three branches.

Sect. 28. deals with the prevention of illness, and care and after-care in the home. Proper enquiries into the patient's home conditions will need to be made in future before a patient is discharged from hospital, so that special arrangements can be made for care until full recovery.

Sect. 29. deals with the provision of domestic helps, and this source offers a great new field for the middle-aged woman too old to take up nursing or midwifery.

That is the framework of the N.H.S. Local Health Authorities are already organised and Executive Councils will take over from their predecessors the Insurance Committee's considerable knowledge and experience. Regional Hospital Boards on the other hand are new. Within the next few weeks the Chairman will meet the Boards for the first time.

Those three branches of the N.H.S. must work in the closest co-operation with each other, e.g. although ambulances are the responsibility of the L.H.A. the efficiency of the Ambulance service concerns the Regional Hospital Board and G.P.'s equally closely. Again the admission of a patient into hospital, and his after-care means there must be the closest possible link between the L.H.A. and Regional Hospital Board. H.V.'s will have to be in close touch with G.P.'s and Hospital Almoner's. D.N.'s will need to work in close association with G.P.'s on the one hand, and hospital nursing staffs on the other. M.C.W. clinics will not be isolated units run by the L.H.A., but will link with pediatric and obstetric services of hospitals. The day appointed for all this to begin is July 5th, 1948.

"THE FUTURE"

The implementation of this new legislation is a colossal task. It is therefore essential to maintain a sense of proportion. 1947 marks the centenary of the first appointment of a Medical Officer of Health in England. The early medical officers of health had the apparently impossible task of dealing with the fearful mortality arising from epidemics of cholera, typhus and typhoid. Many of the legislators of that day were out of sympathy with their efforts. A hundred years later we know that they succeeded beyond their wildest dreams. The health officers of the future have equally important tasks. These are:

1. To detect and remedy the causes of ill health including minor ill-health in the people.
2. To teach the people the art of living. Security is not an end in itself. Also much of the work of today is mechanical and boring. It will be the duty of you and your colleagues therefore to educate the people to ensure happy and healthy childhood and adolescence, the teaching of parentcraft, a love of the home and the proper use of leisure in adults and the employment and wellbeing of the aged.

CONCLUSION

The National Health Service has been criticised that it sets up a National Medical Service and not a National Health Service. This criticism is not justified. The many gaps in the present-day medical services must be filled, but as a whole the Act presents tremendous opportunities for improving the public health. It remains for us to translate these opportunities into reality. ''

Growing Up

THE HEALTH PROBLEMS OF GROWING UP

DR. J. D. KERSHAW.

Recent legislation is making considerable changes in the work of the Health Visitor. The Education Act, 1944, has raised the school leaving age and indicated that education, with, of course, school health services, will, in future, go on much further into adolescence. The National Health Service Act provides for the expansion of all health services and will increase the amount of domiciliary work which nurses have to do. Increasingly, the Health Visitor will find herself concerned with the family as a whole, instead of as a background to the child, and with the child itself over a much longer period, so that the special problems of "growing up" will become more important than ever in her work.

Growing up is a process which goes on far longer than many people imagine. It is not only a physical process but a psychological one, and not only a growing in size but a maturing in quality and power. It may, therefore, be said that few people grow up completely before the age of twenty-five, that most reach maturity—or prime—in the thirties and that some people never grow up at all. It is not possible to deal with the whole of life in this lecture, but it is important to remember that the end of puberty or the end of bony growth is by no means the end of growing up. Child and adolescent care, which is our principal concern, must remember that the child, from birth to maturity, is the same continuous person and that mind and body cannot be considered apart.

It is only possible, in one lecture, to consider a few selected problems and I have chosen some which are often neglected or overlooked. The first is that of immunological growing up. The normal adult is wholly or partly immune to most of the commoner infectious diseases. He reaches this state by undergoing major or minor attacks. The better his general health and fitness the greater is his general resistance and the more likely he is to have only minor attacks of these diseases. Conversely, at times of special strain, general resistance is lowered and more serious attacks of infection may occur—particularly danger periods are first months in school, the period of rapid growth between six and nine years and early puberty.

This is particularly true of infections of the upper respiratory tract, such as coughs, colds and catarrh. The nursery school child, who is for the first time exposed to mass infections at a period of special strain, almost invariably goes through a phase of frequent colds, with tonsillar enlargement and even cervical adenitis; irrespective of age, this is found during the first year or so of school life. It is not, as some people still imagine, an indication for panic tonsillectomy. The tonsils are, in fact, merely doing their job and building up the body's immunity; they

usually shrink to "normal" size in the course of a very few years. The unnecessary removal of tonsils actually retards immunological growing up—tonsillectomy can only be justified if the tonsils, by becoming repeatedly and seriously inflamed, give signs that they cannot do their job.

Another important aspect of growing up is adaptation to physical surroundings. The child is a small person in a large-scale world designed for adults.

From the start the child is faced with tasks slightly or considerably beyond his powers. Door knobs are too high, and the chairs the wrong size. This causes a constant physical strain for the child. Until recent years chairs were uncomfortable even for adults, for various purposes. There are few activities requiring the use of a table which do not distort the usual posture. This does not only operate at the early stages of adolescence. Many people think that because the child does not develop postural defects until later, that the defect has not started early. Bad habits of posture start in a child long before adolescence. These defects in furnishings cannot be remedied in the home, but they should be remedied in the school. Health Visitors should discuss posture problems with the parents, so that they are alive to the problem, and can start teaching the child good posture between five and ten years of age or even earlier.

Many physical efforts of every day life require more strength than the child is able to use. He wants to do everything that adults can do, and does not like being helped. He may over exert himself, and may even injure himself. This is one of the causes of hernia when the anatomical situation is present. Opportunities should be provided for the child to do things which his size and age enable him to do. Parents are usually keen on keeping children within the family, with the result that he is constantly competing with children either older or younger than himself. His recreation should be spent with children of the same age and size. Clubs often provide this opportunity.

Few people appreciate the difficulty a child has in using an adult size water closet, which in any case is not usually very well designed. For a small child, it is really better for him to use a pot, even though this is a nuisance. When the child does use the water closet, he should have a stool provided to put his feet on.

Puberty is a time of the new factor of irregular body development. At any time any tissue of the body may grow irrespective of the rest of the body. Physical growth of the frame causes some strain on the heart and vascular system. Chillblains are often due to the circulatory system growing quicker than the pump. The heart has difficulty in coping with all the work it has to do. Certain murmurs which are traditionally associated with anaemia occur. In all cases of cardiac difficulty in children it should be remembered that the child will always sit down to rest before he is seriously exhausted. Watch to see if the child tires at normal activities, and then arrange for slight restriction of activities. Let him stop at the point where he becomes tired.

Blood is as much a tissue of the human body as bone or muscle, and blood production may or may not go on at the same pace as body

growth. It seems probable that the common anaemias of puberty are caused by temporary failure of the blood-forming organs to manufacture red cells at a rate corresponding to that at which the body is growing and, conversely, that the common nose-bleeding of puberty acts as a safety-valve for over-activity of those organs.

Endocrine upsets occur at this time. There may be all sorts of lags and activity. There may be too much or too little activity of all the glands, including secondary sex glands. The only solution is "wait and see". Cut down any activities the child cannot keep up with. If the child is capable of doing a thing let him carry on, because he needs the satisfaction of achievement. If the child is not allowed a certain measure of achievement he will be unhappy. This may result in maladjustment.

To help the child through all these difficulties there must be greater understanding of physical development by the school. There must be better co-operation between School Medical Staff, teachers, and parents. The child must have an opportunity to achieve.

AFTER-CARE WORK

Miss G. H. Miller

The association of the State with finding employment for young people dates from the time when the Board of Trade established Labour Exchanges in 1909. Some Education Authorities already had their own schemes, but the Board of Trade was regarded as the official department for this work. The Education (Choice of Employment) Act of 1910 gave Education Authorities permissive powers to co-operate with the Adult Labour Exhcanges in dealing with juvenile employment. This was generally unsatisfactory.

Under the Unemployment Insurance Act of 1935, local Education Authorities were given the power to establish Choice of Employment Schemes for their areas if they wished. The Ministry of Labour makes a 75% grant towards the cost of this service. An Education Authority exercising such power, is wholly responsible for the administration of the scheme locally, and has the power to appoint its own Juvenile Employment Officer. At the present time there are, therefore, two methods of operating the service in England and Wales, either by the Local Education Authority, or by the Ministry of Labour and National Service. In Cambridge and County, the Local Education Authority is responsible for the service.

There is some variation of methods, but in general the approach to the boys and girls is during their last year in school. The Juvenile Employment Officer visits the school and talks to the children about Unemployment and National Health Insurance, and the choice of employment in their area. Arrangements are made for parties of children to visit local industrial establishments, and other places of employment. The best results are obtained when these visits are merged into the school curriculum, by prior lessons on the origin of commodities, and subsequent lessons on the processes observed.

Following this introduction to industry, the leaver is required to complete part of a school leaver's card. He indicates his preference for employment, particulars of his hobbies and recreations, his attachment to youth organisations and his father's usual occupation. A portion of this card is completed by the teacher. This part includes the juvenile's educational abilities, and personal trends, together with a broad classification of the type of employment recommended. There is a further section for observations of the School Medical Officer, which is essential to the correct placing of young people into employment.

These report cards are forwarded to the Juvenile Employment Office, from which an invitation is then sent to the parents to meet the Head Teacher and the Juvenile Employment Officer at the school in order to discuss the child's career. Over fifty per cent of the parents attend. The degree of interest shown by the Head Teacher is a very important factor. Frequently the advice given is further education. In the past, Juvenile Employment Officers, in giving vocational advice, have experienced the frustration which arose from lack of adequate facilities for helping pupils whose special abilities merited university training. This difficulty should now almost entirely disappear under the 1944 Education Act, as Local Authorities are empowered to give financial assistance to those capable of benefiting from further education and training.

Parents of retarded children are often advised to leave them at school until sixteen years of age, by which time many late developees are "catching up" on the other children.

There are two chief considerations when placing a boy or girl into employment; the correct assessment of abilities and aptitudes, and an analysis of the actual work to be undertaken in employment. Psychological tests are being used increasingly by the education authorities to assist in arriving at the correct assessment of the child's aptitude, but as these tests require the services of specially trained persons, and take a great deal of time, they are reserved mainly for the selection of apprentices to specific occupations. In Cambridge, aid to the placing of "problem" and mentally unstable juveniles is giving at the Child Guidance Clinic, where psychological and aptitude tests are carried out. This is an invaluable aid to the correct placing in employment of these young people.

Vocational guidance, to be effective, must be supplemented by the finding of suitable employment. When the supply of labour exceeds the demand, well meaning friends and relatives are anxious to help the juvenile find employment. This may result in boys and girls going to a job which is really unsuitable. When the demand exceeds the supply, employers not only use the Juvenile Employment Bnreau to the fullest extent, but issue advertisements and insert notices in windows to meet their requirements. The latter efforts succeed in narrowing the choice of juveniles by employers, and the choice of employment by juveniles. Indiscriminate recruitment has resulted in many boys and girls becoming occupational misfits.

In January of this year, there were no fewer than 16,575 boys and girls under the age of eighteen years, registered as unemployed. In the case of a boy aged seventeen or over, employers are reluctant to engage

because of their impending liability for National Service. A remedy would lie in opening the ranks of the services to them for a period of voluntary service before the conscription age.

Literature on careers is issued by the Ministry of Labour, employers, and Local Education Authorities, so that parents and children may have information about available careers. In Cambridgeshire a booklet on careers is soon to be issued concerning local opportunities for employment.

Local authorities operating the service are expected to make provision for the follow-up or industrial supervision of young people up to eighteen years of age. It is this side of the work that is looked upon by those in the service as "after-care." The term embraces much. The transition from school to work increases the working week from twenty-seven and a half school hours to between thirty-eight and forty-four employment hours, and the strain resulting from this drastic and sudden change affects many boys and girls. There are also other changes. The school leaver finds the world of employmnt a new and only very dimly comprehended one.

The Juvenile Employment Officer keeps a friendly eye on the young people in employment. Each school-leaver, after the first three months in employment is followed-up, both through the employer, and by an invitation to attend an "Open Evening." Boys and Girls replaced in employment are again followed up, through the employer only, unless his report is unsatisfactory. There is a review after one-year in employment, through the boy or girl or his or her parents, Young people approaching their eighteenth birthday are invited to an "Open Evening", with a form enclosed for reply if they are unable to attend.

The response is very good. One is often able to encourage the boy or girl by dropping a hint that the employer is satisfied with his or her progress to date. In like manner, if the employers report has been unsatisfactory, the conversation may be manouvred so that the boy or girl may discover within himself the lack of co-operation, unpunctuality, impetuosity, or whatever may be the failing.

A young person who is employed may register for other employment if he is dissatisfied with his job. Sometimes on leaving school the boy or girl is unable to obtain the employment for which he or she is best suited or upon which he has set his heart. The school-leaver takes a second choice and awaits a possible opening in the desired direction.

In the case of young poeple who do not respond, and those who persistently leave their employment, the After-Care Officer pays home visits, and seeks the co-operation of the parents. In extreme cases arrangements are made for young persons to leave home in order to take a course of training, or efforts may be made to hasten the call-up in the case of young men.

An Education Authority exercising powers under the Education (Choice of Employment Act) undertakes to ensure that all the provisions of the Unemployment Insurance Acts, as they affect young persons under the age of eighteen, are carried out.

Under the "Disabled Persons (Employment) Act, 1944", boys and girls with a disability which would handicap them in obtaining

or keeping employment may apply for admission to the Disabled Persons Register. Vocational training is available to boys and girls over sixteen years of age, and there are residential training centres for the severely disabled. The mentally retarded boys and girls present a difficult problem. There is little suitable employment for border-line mentally defective school leavers.

The report of the committee (under the chairmanship of Sir Godfrey Ince) to consider the measures necessary to establish a comprehensive Juvenile Enploymemt Service advocated, among other things, that Education Authorities should retain their present right to undertake work in their local area, provided their scheme satisfied the Executive; also the establishing of a Central Juvenile Employment Executive which would control policy. This is already functioning and steps are being taken to implement the recommendations of the Committee.

THE MALADJUSTED CHILD

Dr. G. R. E. Richmond.

The matter of the maladjusted child figures largely in the minds of social educational workers just now, and it seems to me, that to discuss maladjustment is to approach a problem which is very often a forerunner of delinquency, and in its earlier stages is observable and sometimes remediable by the social worker or Health visitor. They come in contact earlier with childhood problems than those who eventually have the more specialised care of them, and it is then that so much can be achieved by advice to parents, and constructive help in circumstantial improvements.

The diagnosis of "maladjustment" has been precipitated from the solution of delinquency, by the reagents of experience and increasing knowledge. Fundamentally maladjustment is an emotional disharmony, and behaviour merits this designation when it passes the barrier of what is tolerable, and enters the region of what is intolerable. Maladjustment is often a prelude to delinquency, but it may stop short at that stage, and expand to form a state of behaviour far more difficult to treat than delinquency.

The eventual emotional adjustment of an individual depends on a steady progress through the maze of emotional evolution, to a state of mind in which all the necessary substitutions, displacements, transferences and sublimations have been accomplished.

Apart from the pressure of environment and circumstance, there are hereditary features which may either help or handicap. A child with emotional robustness, will clearly withstand the stress of circumstance far more successfully than the child with more complex emotions. The child may be stigmatized by excessive or diminutive growth, by deformities, defective vision, lack of intellectual equipment, glandular abnormalities, or epilepsy, and physical factors may exert their effect subsequently, such as disease and injury, brain damage, meningitis, chorea or malnitrition.

The environment of the family circle may play an extensive part in training the developing emotions to their utmost, e.g. poverty, overcrowding, sordidness, cramped recreational facilities, and the more blatant evidence of neglect, discord, alcoholism, violence, quarrelling, infidelity, separation, death, step-parents, illegitimacy and desertion. These are some of the catastrophies which are on a child's emotional life, rather as a steam hammer on a thrush's egg. A child instinctively craves security, consistency, affection, and tranquillity in the home, intensely disliking scenes, squabbles and frightening noises.

To merit a diagnosis of maladjustment, one or more symptoms must have rendered the child's conduct insupportable to the family, or school unit, or to the community as a whole.

The range of symptoms and behaviour manifestations varies considerably in intensity, and usually there is an easily recognisable pattern, nervous habits—the toll of insecurity—such as nail biting, knuckle and lip biting, and tics, some forms of chorea, nose picking, insertion of foreign bodies into any of the orifices, are frequently found. One of the most distressing symptoms is enuresis. Some say it is due to lack of training, laziness or cussedness, and there are many suggestions for treatment, but the fact remains, that very many children with enuresis have other symptoms which point to maladjustment. Sometimes there is a physical cause, such as need for circumcision, but the greater tendency is shown by deprived children living under institution conditions. Shock, separation or anxiety (as in evacuation) may cause onset and relapse of enuresis. The condition will often cease temporarily if the environment is changed, but it relapses after a time.

The basis of treatment, however slow, is the aim of a steady increase in security, of loving kindness, and to treat the matter as unobtrusively as possible. Rewards, charts, and other means of encouragement have proved of doubtful value, and punishments are likely to prove a grave cause of psychic trauma. As a child gains confidence and assurance of security, the enuresis slowly disperses, but of all the symptoms of maladjustment, I think there is no greater hindrance to adjustment, and however little is said the child feels ostracised, and may react with compensatory aggressiveness, or anti-social behaviour, or may be driven further into his shell. Day enuresis and soiling are further complications, and are usually the pathetic outcome of a feeling of insecurity and rejection.

The parents may describe an excessive frequency or severity of temper and tantrums, undue destructiveness, a seemingly malicious propensity to damage property, bullying, cruelty to animals, truancy from home or school, and sexual aberrations. I think the matter of masturbation is often overstressed.

Within the framework of maladjustment in children, any form of delinquency can be committed, including murder. Stealing occurs in a very high percentage of cases. A child may show marked introversion or extraversion. It may play on its own, and find unusual difficulty in joinlng in team games, and there may be excessive indulgence in day-dreams and fantasies in an attempt to seek in imagination, the love and fulfilment hitherto unknown. On the other hand, extraversion may

assume the proportion of gangsterism, an exaggerated desire to share company and adventure with others. The child may show periods of undue depression and moodiness, and of overactivity.

There are often symptoms of psychoneurosis in these maladjusted children—excessive fear, timidity, shyness, anxiety, fear of the dark, nightmares, sleep talking and walking, or excessive boldness and an nnnatural lack of appreciation of risk and foolhardiness. There may be signs of hypochondriaris, such as headaches, giddiness, fainting attacks as opposed to true epilepsy, dyspepsia, undue finickiness with food, or a voracious appetite, attacks of diarrhoea and vomiting, and unexplained rises of temperature.

Unfortunately, many maladjusted children are of low grade intelligence, and most of the residential establishments for this type of child are not disposed to take one with an I.Q. of less than 100.

Truancy is usually the result of incapacity or intense dislike of school, and cannot be overcome by the usual methods of education. Truancy from home is often evidence of deprivation or rejection at home.

There is a special type of maladjustment observable in an institution child, and it is apparent to any visitor within a few minutes of entering. It is difficult to satisfy the emotional demands of a child amongst the number that an institution is wont to contain, and the children will crowd round, and want to touch any visitor. As the child grows up, it may become docile, lacking in initiative, colourless, well disciplined, almost excessively tidy, but lacking in individuality, or psychoneurotic symptoms may become accentuated, because the child may have too great an individuality to allow itself to succumb.

Glandular abnormalities have been investigated thoroughly, but apart from gross abnormalities, the treatment has been disappointing. The Thyroid gland in the deficiency of cretenisin, or the overactivity in the form of goitre, causes extremes of maladjustment; on the one hand dullness and the appearance of a cretin, and on the other, mental and physical overactivity. The Pituitary gland, by overactivity of one of its lobes causes in children, undue adiposity and undeveloped genitalia.

The Epileptic child is often maladjusted to a grave extent. The sporadic excitability of the cerebrum, though not always amounting to fits, may cause impulsive violent, delinquent behaviour.

Disease and injury to the brain and spinal cord, e.g. meningitis, cerebrospinal meningitis, anterior polioymelitis may result in maladjusted behaviour. Prolonged illness with its accompanying repression to infantile associations with mother or nurse, may delay or fix emotional development.

Adolescence is a time which presents problems to both parents and children. There seems to be a slowing up of the mental processes, increased moodiness, obstanacy, laziness, criticism of parents and teachers, and there is a good deal of self-analysis. It is a time of almost fanatical opinions. The mental and bodily torpor is sometimes relieved by bursts of mental and physical activity. Emotions are easily aroused, and intense. The metabolism of the body fails to keep pace with the demands upon it, and facial acne is common. Potential maladjust-

ment becomes actual during this period, and the primitive urges most insistent. The onset of menstruation is often a serious shock.

During this phase, when as much tranquility as possible is vitally necessary, the adolescent is faced with examinations, on the result of which will depend success or failure of long laid hopes and plans.

The Health Visitor is ideally placed, in her intimate knowledge of the homes, to prevent, diagnose and assist in adjusting the symptoms which have been mentioned by:—

1. The easing of overcrowding where possible.
2. Persuading the Local Authority to carry out repairs or vital additions to hygiene and comfort.
3. Assist family in any way possible, to raise their standard of living where necessary.
4. Adjustment in family circle, calling in social worker, vicar, priest or doctor if necessary.
5. Personal influence can be utilized to persuade a husband to drink less, or treat his wife more gently.
6. Symptoms can be pointed out to the parents and explained, thus attempting to change intolerance and contempt to understanding.
7. Remedies can be suggested.
8. Sexual guidance for older children can be advocated. I think individual instruction in this is the wisest.

In family life, love and security are the vital foundations of stability. Child guidance clinics, psychiatric treatment, and thousands of hours of work done by Social Workers, are at the best, some sort of attempt to form a substitute for love.

I do not think that Day Nurseries for children under 2 years are suitable for the potentially maladjusted with insecure homes. For the older children, cubs, scouts, choir, and other youth organisations are invaluable. I believe that religious instruction is a necessary background for the evolving mind to assimilate an interpretation of truth in terms of love and simplicity. Worship and teaching should be shared by the parents, and not just be used to enable the parents to have a quiet afternoon.

When we have left childhood behind us, it is no longer possible to see life with a child's eyes. We are too inclined to judge what they do by our adult standards, and to expect children to react and behave as we think we did.

I think I could not close on more pertinent lines than these, written by a Persian Poet in the 3rd Century:—

"You may give them your Love, but not your thoughts,
For they have their own thoughts;
You may house their bodies, but not their souls,
For their souls dwell in the house of Tomorrow.
You may strive to be like them, but seek not, not to make them like you,
For life goes not backward nor tarries with yesterday."

HEALTH OF THE SCHOOL LEAVER

By Dr. H. Smith.

Regulations made under the Education Act provide that pupils must be examined in their last year of attendance, i.e. just before they reach the age of 15 years. Until now, pupils in most areas were examined at 12 years, and not again unless they attended what we called Secondary Schools.

In London, however, we have for very many years now, examined an additional age group, and all children were examined in the term before that in which they were due to leave school. This has enabled any defect to be remedied as the child is always 'followed-up' in the term to ascertain whether any necessary treatment has been obtained. At the last examination medical officers have filled in a "Leaver" Slip, upon which are specified any contra-indications to any particular employment. A form of this nature has now been suggested by the Ministry of Education for general use all over the country.

A Lecture on this topic enables one to take stock, to ask ourselves "Have we achieved as much as we should have done?"

The School Medical Service was primarily established to render children fit to receive the education provided by the State, but its scope has extended through the years until today, under the 1944 Education Act, Education Authorities have become responsible for comprehensive medical teatment other than domiciliary which latter will become available free under the new National Health Service Act.

In the time available it would be difficult to give detailed statistics of all aspects though I will give a few later. It may be true that in the case of some individual children the school health service has failed, but generally speaking the school leaver of today has a far better physique than his predecessor of even ten years ago.

There is less malnutrition, less tuberculosis, less ear disease, less severe deformities; defective vision is more corrected and the children have better teeth.

Of the London school entrants in 1946, only 69% had sound teeth as compared with 81% of leavers!

Four or more carious teeth were found in 6% of entrants, but only 1.2% of leavers.

It is interesting to note that more than 80% of 1946 "Leaver" Boys and Girls had been immunised against diphtheria.

In regard to personal hygiene, the London figures show that the incidence of pediculosis in boy leavers is 50% less than that in boy entrants, but the incidence in girl leavers is 25% greater than that in girl entrants.

It is disturbing to find in the Annual Report of the Chief Inspector of Factories that of the young persons examined by Factory Surgeons prior to entrance to certain employments, nearly 50% of those deemed unfit are rejected on account of pediculosis.

Generally speaking, the facilities provided for treatment of all defects is good, and the co-operation of parents readily given.

The usual experience of us all is that it is those cases where the parents do not co-operate which cause the most concern.

Where do we fail? In my opinion it is in the field of Health Education. All our work is in vain if the pupil, when the time comes for him to leave school has not learned the simple rules of healthy living and how to maintain his health.

The Board of Education, as it then was, has, from time to time, issued a Handbook of suggestions on health Education. It was last re-printed in 1939. This handbook states that in the last year of school life pupils should be expected to know how to keep themselves healthy and clean; how to render simple first aid; what precautions should be taken to prevent the spread of infection, a knowledge of social services; and in the case of girls how to do elementary sick nursing and a knowledge of mothercraft.

The stress has always been against the use of specialist teachers for these subjects, but in my view the ordinary class teacher has more than enough to do with her routine subjects with the result that health education is neglected. There has been much stress, too, recently on education in its broadest terms but educationalists seem to forget that their work may be vitiated by the lack of knowledge of the simple rules of health.

In London our school nursing sisters are giving increasing numbers of courses of Mothercraft to girls, and their services are available at the request of head teachers for talks on personal hygiene. School doctors and nurses are only too ready to play their part in this wider view of education.

Members of your organisation have been fitting themselves for this work by attending courses in the art of teaching. This task will not be easy under present conditions, when many schools are badly lit and ventilated, when washing conditions are poor, and sanitation in some cases, primitive.

To summarise, the present-day school leaver is a far healthier child than his predecessor, his defects are remedial but he still lacks the knowledge to maintain the results of the School Health Service, into adolescence and later life, and my plea is therefore, that health education should become a feature of the syllabus of the pupils' last year at school.

SCHOOL MEALS

By Miss Elizabeth Mason

It is now fully recognised that correct feeding during School years plays an important part in the child's physical development and mental achievement. A well-balanced school meal not only benefits the health of the child, but has an important educative value.

The child who has a well balanced meal every day becomes educated as to what a meal should contain. This form of nutrition education has the advantage of including both boys and girls whereas, generally speaking, boys receive very little in the way of instruction in nutrition in their normal school curriculum.

The question has been raised as to the value of one good meal a day, when the other meals may be inferior. One good meal a day is of great value to the child. In 1938 an experiment was conducted in Stepney.

A school was selected where the children were having a very indifferent midday meal. A group of children were given in place of this indifferent meal, a well-balanced "Health Dinner", based on the Oslo breakfast. The meal was devised to supply the protective factors, in which the diet of the poor child was likely to be deficient. The two groups of children, namely the children on the "Health Dinner" and the children on the indifferent meal, were compared over a period of several months.

The children were weighed and measured weekly, and had regular medical examinations. By comparison with the control group the children on the "Health Dinner" showed:—

a. A greater gain in height and weight.
b. An absence of minor ailments and healthier skin.
c. A rise in the haemoglobin level of the blood.
d. In many cases an improvement in school work.

The teachers also reported these children were full of vitality.

In planning meals for school children it should be borne in mind that they are growing rapidly, and therefore, they have a great need for protein and calcium. Meals must be highly protective to ensure proper development, and good bodily resistance to disease. School children are usually very active for their size, and therefore have a relatively greater need for calories than an adult. The capacity of their stomachs is limited, so meals should not be too bulky.

In planning school dinners it is important to remember that filling and feeding are too very different things. Well balanced meals are ones which contain, in the right proportion, all the food factors needed for good health.

In dealing with the subject of the planning of school meals it is perhaps simplest to deal with the subject under three headings, energy giving foods, body building foods, and protective foods.

Energy Giving Foods

It should be remembered that adolescents have a very high calorie requirement, and should be given the opportunity of having extra helpings of unrationed energy foods.

The maxim "choose your calories for the company they keep" is especially applicable in the case of the school child. Energy foods which are most valuable are those which provide in addition to energy other nutritive factors as well. An increase of sugar is not desirable, as it is one hundred per cent carbohydrate and provides nothing in addition to energy. It is important that children should be taught to like brown bread and brown flour rather than white.

Body Building Foods.

In the case of body building foods, full use should be made of animal proteins. Special emphasis should be laid on milk and cheese, because these foods, in addition to providing protein of high biological value, are also an excellent source of calcium. Dried milk and dried eggs, from a body building standpoint are excellent foods. Dried milk can be incorporated, in a dry state, into puddings and mashed potatoes. Dried egg should not be left standing after it has been reconstituted. With reference to the vegetable proteins, soya flour is one of the best.

Not too high a proportion should be used in any one dish, however, or else the rather characteristic flavour will predominate.

There is a supplementary action between proteins. This is the ability of one protein food to make good the amino acid deficiency of another protein. Animal protein should be spread as evenly as possible throughout the week. This is of greater value to the child than having a lot of animal protein one day, and none the next. To make use of supplementary action, combine animal and vegetable protein in the same meal.

Protective Foods.

Protective foods are those which guard against the deficiency diseases build up the body resistance to disease, and give a sense of well being. Vitamins A. and C. are the two protective factors which are most frequently lacking.

Vitamin A is essential for correct growth in childhood, and for the health of the eyes and epithelial tissue. The best sources of vitamin A are liver, oily fish and dairy foods. Green and red vegetables contain the precursor carotene, which is changed by the body into vitamin A. For adequate Vit. A. in the School meal, fish (oily) and liver should be introduced, when available. Liver may be minced with other meat. This serves a double purpose, it spreads out a small amount of liver, and also disguises it for children who don't like it. In addition, to guard the vitamin A intake good helpings of green and red vegetables should be served.

Vitamin C is needed for buoyant good health and vitality, and for the health of the gums. Lack of this vitamin causes lowered bodily resistance and slow healing of wounds. Scurvy is the deficiency disease associated with a lack of Vitamin C. There are two sources of this vitamin, fruit and vegetables. The best fruits are rose hips, black currants and the citrus fruits. The best vegetables are those of the green and leafy variety. Potatoes may be regarded as a good source, especially new ones, because of the amount eaten. For adequate vitamin C in school meals stress must be laid on both raw vegetables, and correctly cooked vegetables. Vitamin C is affected by four factors, leeching into the cooking water, oxidation, heat, and a ferment called asorbic oxidose, which is present in the vegetables. It has been found that cooking vegetables in the conservative way is best. Keeping vegetables hot for a long time should be avoided as far as possible. In school meals, potatoes ahould always be accompanied by a second vegetable, frequently of the green and leafy variety. Dried pulses contain no vitamin C, and therefore do not take the place of a fresh vegetable.

Bicarbonate of Soda should be avoided if possible in cooking greens, it should be used only if absolutely essential for good colour. If bicarbonate of soda has been used, serve the greens as soon as possible after cooking, as the rate of vitamin C destruction during the ''keeping hot'' process is many times more rapid when bi-carbonate of soda has been used.

Every child should be encouraged to have a school dinner. It has been stated that the wealth of a nation lies in her children. Let us do all we can now to see that the school children of this country are properly fed.

A Happy Home Life

PREPARATION FOR MARRIAGE

By Dr. David R. Mace.

In the past four or five years we who work in the Marriage Guidance Council have had the task of dealing with many thousands of marriage breakdowns. The conclusion at which we have arrived is that in most cases the trouble could have been prevented if those concerned had been properly prepared before they embarked upon marriage. We therefore believe that the long-term solution to the broken home lies in the widespread provision of such preparation.

In the fullest sense, preparation for marriage covers three stages:—

1. *From infancy to puberty.* Even in childhood, ideas about marriage are being formed. In this period there are two things which will help to ensure that these ideas are the right ones.

First, it will make a great difference if the child has *a happy home background.* In his own parents he sees marriage as a good thing. He believes in it, and that helps him to make his own later marriage a success. The child of an unhappy or broken home has no inner confidence in his capacity to do better than his parents. When he meets difficulties in his own marriage, he tends to despair and give up. So good marriages in one generation beget good marriages in the next.

Second, the child should have a sound *sex education.* This involves three requirements. First and foremost, he must develop a wholesome *personal* attitude towards sex. His parents are the best people to ensure this, if they can answer his questions and satisfy his natural curiosity so that he accepts the fact that sex is essentially a good thing. Then he must also develop a right *social* attitude to it. The school must help here, by creating a healthy attitude to sex amongst the children so that when they discuss it among themselves they do so in a wholesome way. Further, the child will at some time require to be given a systematic knowledge of the subject, to provide him with a basis upon which to work out a sound philosophy of sexual behaviour. This also can probably be best done in the school.

2. *From puberty to mate selection.* At puberty sex awakens as a dynamic force in the growing boy and girl. Now it is not a matter merely of right thinking and feeling, but also of right *conduct.* The youth is much more likely to develop right patterns of behaviour if he has been given right mental and emotional attitudes beforehand.

In this period young people will need guidance about *moral standards.* They should be frankly told the facts about masturbation, about homosexuality, about promiscuity, about venereal disease. If they are left in ignorance they may take the wrong turnings which can damage their capacity for good marriage adjustment later. The ignorant youth or maiden is always liable to fall a victim to the unscrupulous and perverted adult.

Above all, the adolescent should be guided as to the right approach to *mate selection*. The choice of the marriage partner is so important that young people should have formed some standards of judgment before they reach the age of falling in love. It is not easy to tell them after the event that they have made an unsuitable choice.

The free admixture of young people in work and play will help them to form experienced judgments and not to take each other at face value. Mixed clubs and other organisations can serve this purpose, and in that way contribute to good marriage.

Young people need teaching about the value of our traditional code of courtship and engagement. Properly used, it provides the means by which the couple can thoroughly test out their personal suitability to each other, so that they do not marry on a basis of sex attraction alone. In this preparatory period they can grow naturally towards a true fellowship of mind and heart until they are fully ready for marriage. All this is liable to be spoiled if physical sex is thrust in at too early a stage. It should come as the consummation of their fellowship at other levels. Sex used to express less than the total fellowship and total commitment to each other of a man and a woman is being used at a sub-human level.

3. *From mate selection to marriage*. The engaged couple are in the right frame of mind to receive much more specific and detailed preparation. They require a good deal of instruction about the technique of marital adjustment, so that they may not make foolish mistakes and hurt one another unnecessarily. They should have a pre-marital medical examination, when questions of general health and family history, as well as sexual fitness, can be enquired into. If necessary they should also have a psychological check-up. In addition to teaching about marriage itself, they should have some sound instruction on parentcraft and on home-making. The aim of all this is to send them into marriage as well fitted for it—physically, mentally, emotionally, and spiritually—as possible. We believe that if this could be done on a widespread scale, a great deal of the marital conflict which at the present time is costing us such a bitter price could be avoided altogether.

How is all this to be done? The first part of it, the more general education will have to be carried out by the co-operation of many people —parents, teachers, youth leaders, and others. The second and more specific part can be carried out through the marriage guidance centre. We are already doing this on a small scale, and are planning to extend and develop it.

At the London Marriage Guidance Centre, a full course of marriage preparation has been worked out for engaged couples. First there are four lectures, on the foolowing subjects—1. Marriage as a personal relationship. 2. Marriage as a sex relationship. 3. Parenthood and family life. 4. The art of home-making. The next stage is an informal talk with one of the lecturers, to bring out and answer any personal difficulties or queries, and to serve as a general psychological check-up. Finally, there are two interviews with a doctor, in which all the relevant medical questions are thoroughly gone into.

We do not claim that even this full course of preparation will guarantee the couple against later trouble. But we are confident that it will

greatly improve their chances of good adjustment and therefore of happiness. Moreover, our work does not end when the couple marry. Part of the aim of our preparation is to give the couple an enlightened attitude towards marriage, and to establish a friendly link between them and the centre, so that in the event of their falling into trouble later they will quite naturally come back to us for help before the situation has reached a serious point.

In this way we hope, through the years, to build up throughout the country, a great and growing company of married people who will set a new standard of sound marriage and happy and healthy family life.

FAMILY BUDGETTING

By John Stamps.

Man is composed of 3 parts. Mental, physical and spiritual, and it is essential that all 3 be catered for.

Mental. This affects the ability to plan, and heredity and training are involved.

Spiritual. What a person's standards are, and what he hopes to achieve, will affect his outlook.

Physical. This covers more than one aspect. *Health* affects the economic stability of a family.

Economy is a kind of morality in small things.

1. Management of household.
2. Prudence in use of money.
3. Harmonious organisation.
4. Thriftiness.

Budgetting means taking into account one's needs and one's resources, and apportioning those resources to the needs.

We must acknowledge that there is greater need for family budgetting now than ever before. We see an upward trend in the income levels, but a scarcity of consumer goods which that money should be buying.

Family Budget Spending.

Rent. This is always the first consideration. It should not exceed 1/6th of total income, but one cannot be too specific about this in these days.

Insurance. This commitment, once undertaken, cannot be reduced without involving the family in some financial loss. Insurance can signify thrift and providence or can portray a complete absence of these. Some spends as much as 9%, 10% or even 20% on this.

Food. This is usually the largest single item of expenditure. More opportunities must be provided for the teaching and learning of housewifery, and all that the word implies—e.g. dietetics, child care, hygiene, etc. More money is spent at the greengrocers and fishmongers than at the grocers, and it is a generally accepted fact, that though meat, fats, bacon, eggs, sugar and tea are rationed, the actual cost of feeding a family is far in excess of pre-war. Lack of adequate cooking equipment or

storage space can increase food costs. Planning meals several days or a week in advance, results in good nutrition, and economical use of time, money and ration points. Food should be raised and preserved at home as much as possible.

Clothing. The cost of clothing, along with food and shelter completes the main spending. Make do and mend Classes have helped enormously regarding clothing expenditure, and many women have developed a talent of which they were unaware. It is best to work from a base:—

1. Make an inventory of clothes possessed by each member of the family.
2. Make a list of clothing that can be repaired and altered for a younger child.
3. Make a list of clothing required during the next 6/12 months in order of its urgency.
4. Consider the social and work life of the family.

Cardinal considerations in selecting clothing should be—durable fabric, ample fit, and conservative type.

Household Furnishings. Families who were in existence before the war, and who are now badly in need of replacements, should refrain from buying anything but the really essential articles. The planning of newly-weds needs to be focussed, not only on the immediate need, but on a future possible family also.

Operating Costs at Home. Included in this item are various things, small in themselves, but representing a large part of family expenditure. Coal and soap being rationed are easy to assess. Burning logs and wood is no longer an economy, but an essential need and the increased demand has led to higher prices.

Electricity and Gas are difficult to budget for because of increased use of equipment in all homes. Some of the voluntary saving methods now in use, however, are so little trouble that they will be continued.

Laundry can entail high cost if the housewife is unable to do the washing at home. The wear and tear of commercial laundering, and the length of time between collection and delivery means that a larger supply of clothing is required.

Recreation and Entertainment. Certain items under this heading are universal today, e.g. wireless, cinema and the theatre. The cost of holiday accommodation is greater now than ever before, and there is a great increase in gambling—mainly in the form of football pools. Spending on recreation or entertainment is such a personal matter, that each member of the family should have a personal allowance.

Savings. For families above the subsistence level, saving for the future is an important part of budget planning. Savings represent provision against any emergencies which may arise, or goals to be attained *re* the education of children, etc.

Successful budgetting means maintaining a sense of balance. Excess in one direction may mean sacrifice and deprivation in another.

ADOPTION

By Dr. D. H. Geffen.

Under the Adoption of Children Act, 1926, a Court may, on application by a person desirous of adopting an infant, make an adoption order, authorizing the applicant to adopt the infant. Before this Act, an "Adoption" had no legal rights or obligations, and the child could be reclaimed by its parents at any time.

Under the present Adoption Act, an applicant must not be under 25 years of age, nor less than 21 years older than the infant, unless the applicant is the mother of the child, and must be resident in England or Wales. The "infant" must be under 21 years of age, unmarried, a British subject, and resident in England and Wales.

A man may not adopt a girl except in special circumstances, e.g. A married couple may adopt jointly. A mother can adopt her own illegitimate child. If both parents were free to marry at the time of the birth, the father can legitimise the child if they marry later.

A Court must be satisfied that an order if made, will be for the welfare of the infant, and the consent of the parents, and other interested parties is necessary. If the person who is to be adopted is old enough, his wishes must be considered. There must be no reward either for parting, or receiving a child. It is illegal to advertise a child for adoption.

A guardian, ad litem, whose duty it is to safeguard the child's interests, and report as to suitability of home and applicants, is appointed by the Court. This is often an officer of the Education Authority. The Court can grant an Adoption, or postpone it for 2 years.

Applications can be made to the High Court, County Courts, or Juvenile Court, and the application can be heard in camera.

The general effect of an adoption order is to transfer from the infants' parents or guardians to the adopter, all rights, duties, obligations and liabilities with regard to the infants custody, maintenance and education. If the child does not receive proper care, adoptive parents can be dealt with under the Children and Young Persons' Act. An adopted child can be re-adopted, with the adoptive parents' consent.

Being adopted does not alter the infants' status regarding his succession to property. If an illegitimate child's own mother dies intestate, he is not deprived of his legal right to money or titles. If the adoptive parents die intestate, or leave money to be divided among "their children," he does not inherit unless specially mentioned by name. If an adopted child dies intestate his money goes to his own parents, and not to his adopted parents.

In 1927— 2,967 Adoption orders were granted.
In 1937— 5,500 Adoption orders were granted.
In 1942—10,417 Adoption orders wdere granted.
In 1947—16,357 Adoption orders were granted.
(90 High Courts, 2,622 County Courts, 13,654 Juvenile Courts).

The demand to adopt children now far outweighs the supply, and the waiting list for girls is twice as long as for boys.

When the adoption order is made, the Registrar General enters the

child's name in the Adopted Children's Register. This register shows the name of the child as adopted, date of adoption, and date of birth, if known. The records kept by the Registrar show the child's original parents and are only used under very special circumstances, e.g. to trace the origin of an adopted child who dies intestate, or who is entitled to inherit. To see these records an order of the court is required.

A full birth certificate shows the above details, and can cause a great deal of embarrassment and distress. A new type of birth certificate will be avilable on January 1st, 1948, which gives only the name, address and date of birth, with no reference to origin. As these certificates are allowed to be purchased by anybody, at the low cost of 7d. it is hoped that the full birth certificate will only be used for special purposes.

1939 Adoption of Children Regulations.

Before this date, any society or individual could arrange adoptions. Now, every adoption society must be registered by the Local Authority, which is the County, or County Borough. A L.A. can refuse to register an adoption society, and registration can be cancelled if rules are not kept.

REASONS FOR REFUSAL.

1. Societies must not be run for gain.
2. Societies must have adequate staff, suitably qualified.
3. Societies must keep approved records.
4. Societies must have a Case Committee.
5. No one employed must have been convicted for cruelty or neglect.
6. Children must be medically examined.

Some adoptions are arranged before the baby is born, and sometimes by Maternity Hospitals. A girl who has just had an illegitimate baby, is seldom in a fit condition to understand the complete position that arises when she allows the baby to be adopted. It is not often that a mother will part with her baby ofter 3/12 breast feeding. Depriving a mother of her child must not be taken lightly, she may regret it later on, if she marries and has no children.

Only a proportion of illegimate children are adopted. Many of them go home with their mothers and are absorbed into the family. If the mother marries, the child is often accepted by her husband.

HINTS ON DISCUSSION GROUPS

MISS POWLETT AND MR. WHITELAW.

The Setting for a Group.

The most important thing is a friendly atmosphere. The room should be light and cheerful, not small enough for people to feel overcrowded, and not large enough for the empty spaces to cause self-consciousness. Chairs should not be arranged in rigid rows, but into a group. This will lend an air of informality to the proceedings, and people will automatically settle themselves into a friendly circle, where

everyone can see those changes of facial expressions which make discussion more vivid.

Tables should be pushed to the back of the room. Wherever possible allow smoking, sewing or knitting. This will ease the conscience of those who feel they are wasting time, and gives the shy something to hide behind. Actually, after the first few minutes, the interest becomes so intense that the work is forgotten. If a pot of tea is available, informality is assured.

The number taking part should be 8—15, less than 8 makes each individual conspicuous, and this may prevent easy expression. Over 15 is too like a public meeting, and a friendly atmosphere will become a competitive one, in which too many people are struggling for the leader's attention. Since one of the values of discussion is that everyone should be able to take part, it is particularly undesirable that numbers should create a situation in which several are found to be mere spectators.

The Group Leader.

A friendly easy personality is more important than specialised knowledge. The Group Leader is not a teacher, but should be more like a good hostess who has the knack of making people feel so much at home, that they will together produce ideas and suggestions, which will make a first class discussion. It is important that the group should feel sincerity and a willingness to submit opinions to a reasoned examination by all. The leader should have the gift of asking the right questions to stimulate clear thought, but should not be a provider of answers, for conclusions should be a group achievement. It follows that the leader should not be a dominating personality desirous of being the central figure in the way a lecturer is, rather, she should quietly serve the group by gathering the seperate threads of thought into a neat web. Another way in which the leader serves the group is by keeping an eye on very talkative persons, who like to occupy more than their share of the limelight. These people can spoil it for the quieter, but not necessarily less thoughtful ones. A useful way to interrupt their flow and at the same same time to encourage the silent is "That was a very interesting point Mrs. So and So, I wonder what the rest of the group feel about it?" Shy people need handling with great understanding. While a direct question may make them dry up permanently, they can often be encouraged to speak by bringing the discussion round to aspects of the subjects with which they are familiar. For instance, the leader knows that Mrs. B's child has recently had measles, so in a discussion on infectious diseases, she innocently asks the group "I wonder if anyone has been nursing a measles case in the last few years? 10—1 Mrs. B. will speak before she realises she is doing so, and will become so interested in retailing her experiences that she will forget she arrived feeling she would never dare to speak. Once she has taken the plunge, it will never again be difficult to join in, particularly if the leader cunningly refers to the interesting point raised by Mrs. B. This encourages her to feel she might speak another time if the group was interested in what she said.

Choosing a subject.

Ideally, it is best to ask a group what they would like to discuss, but this is not always practical. However, the leader can generally find out the interest of the group, and with those in mind, pick a subject which will appeal to everyone. Interests are not the things we all no doubt ought to think about, but the everyday things that Mrs. Smith spends 3/4 of her time doing, talking about, and just imagining. These to most women are food, queues, clothes (or coupons), husbands, children, homelife, films and perms, are much more intimately interesting than Public Health, Economic planning, Taxation, the Atomic Bomb, or the prospects of the United Nations. These latter things are vitally important, but the average housewife does not think about them until they impinge on her everyday life—as in some cases happened during the war. In the same way, she cannot be brought to discuss Public Health with that zest which makes for a worthwhile discussion until the leader links the subject with her everyday wants and fears.

Making the Subject come alive.

The first step to decide, is where the subject impinges most vividly upon the everyday life of the group. You should then choose a title reflecting this aspect, which will probably provoke more thought if phrased as a question. For instance, Diptheria Immunisation is an important topic, but uninspiring left in that form. Would not the average mother be far more interested in a discussion on "Is my child in danger from diptheria?"

The next step in making the subject come alive, is a vivid but short introduction. This can take the form of visual or other aid, or it can be merely a few evocative or descriptive sentances that put people into the frame of mind in which they want to discuss. We live in an age of showmanship, and your group has to compete with the standard of attraction set by the press, films and radio.

There are several types of introductory aids, and the easiest is to produce something for the group to look at, as most of us learn by what we see rather than by what we hear. For instance, in a discussion on clean milk, you attract the group's attention by a (possibly humorous) picture of a cow, and then go on to some enlargements of noisome germs and their rate of multiplication in dirty milk. At this point the group should have become so interested that they would be ready to discuss why the germs occurred, and how to safeguard the children from them.

Another kind of aid is the dramatic script; beforehand you write out the parts of an imaginary conversation by two mothers on some health problem. The extremes of both points of view can be touched upon, if possibly humorously, and brought to life by getting two members to read the script. You will find that people carry on naturally from there.

How to make facts available without giving a lecture.

Whenever possible the leader should avoid any appearance of providing the information necessary for a good discussion. To do this tends to make her far too much of a teacher so that she seems to be

apart from and superior to the group. She should use her ingenuity to find means of projecting that information impersonally either by easy and attractive pictures and charts which all can study together, or another aid can be used by which the group build up the necessary basis of fact. For instance, a discussion on food and rationing might be started by asking the group to remember the enjoyable meals they had before rationing began, and asking them to mention which foods each misses most. As people say bacon, meat, sugar, and so on, the leader hands out cards bearing symbols for each food—a pig for bacon, sheep for meat, and so on. These symbols utilise the figures last quoted by the Minister of Food, as the weekly average received per perosn, and t show these quantities each symbol stands for 4 ozs. (or pints in the case of milk). Thus while there is only a portion of a pot of jam, there are quite a number of bags of flour and so on. To contrast with present day amounts, a second set of symbols is handed to the group with the average amounts per person in 1939. When each member of the group has pinned her own two sets of symbols on to the board, there is thus demonstrated a clean, factual contrast in food quantities then and now. Many of these facts are new and surprising to the group, who will start exclaiming "But how amazing, there is more milk available now than before the war, where does it go to?" and so on. This natural reaction can be utilised by the leader to start a discussion on priorities, is there any waste of milk at school? and other related subjects. This form of aid can be adpated to any discussion requiring a basis of statistical facts. It is a method which not only induces thought, but creates impact and co-operation by getting the group moving about and doing things. It is a commonplace that there is a close connection between what happens between our bodies and our minds. This particularly applies in discussion where the shy person who sits rigidly tense with embarrassment at known lack of knowledge, will be greatly helped by moving about in the anonymity of a group of mothers doing the same thing.

Changing Talk into Discussion.

Having aroused interest and co-operation, even though in the form of mere statements of opinion, the leaders' next step is to induce the group to try to sort fact from opinion, and then to discover the implication behind the facts. This is most effectively done by questions of the How? Why? For what purpose? variety which get the group into the habit of testing its own ideas.

The leader should, if possible, avoid answering questions herself, she should pass them back to the group with an air of "I wonder which of us can help solve that one." It is very rare that no-one has a clue, but the leader must have enough faith in her group to let them take their time. It will usually be found that the group between themselves possess a suprising total of information, while the very things they do not know, can be collected as series of questions to be answered by next meeting This can either be done by a co-operative group effort in which each member volunteers to tackle the query with the help of a librarian, books or films, and bring the answer next time, or the group may request an information session in the form of a lecture which will fill the gaps revealed by discussion.

The important point is that this informal method has aroused interest in the whole subject and a positive appetite for information, instead of thrusting facts upon a passive audience.

WHAT ABOUT CONCLUSIONS?

Since a discussion group is not a Cabinet Meeting after which effectice action must be taken, hard and fast conclusions are not the aim. The object of discussion is for the group to clear its mind upon a problem, and separating fact from opinion to advance, if possible, towards a solution, even if this at first consists in realising clearly what one does not know. In fact, discussion wil probably show what further questions to ask, rather than produce final answers.

This does not mean that the meeting should end in vagueness; it is highly desirable that a brief summary should be made of points raised and what the group thought about them, not ommitting minority opinions. This enables the group to leave with a sense of achievement, and gives it a starting point for further co-operative effort, either by discussion, or seeking direct information.

Inexperienced leaders may find it very difficult to take down the summary, which is an intaking activity, at the same time as carrying on the out-giving job of group leading. To get over this difficulty it is often worthwhile to appoint a secretary beforehand, who will note very briefly the main points raised and the group's reaction to them. This, of course, should not prevent the secretary from taking a normally active part in the discussion herself.

In order to demonstrate the above principles a discussion was held on "Can Housewives afford Leisure Time?"

CARE OF THE AGED AND INFIRM

THE RT. HON. LORD AMULREE.

The problem of the care of the aged and infirm has been much discussed during recent years. Not much of constructive value has resulted.

The age at which a person may be considered old is arbitrary; but the pensionable age, sixty-five for men and sixty for women, is usually accepted. This has no bearing on the person's capabilities or powers. In 1900 there were about one and a half million old people, in 1947 about six million. People are, generally, living longer. In 1900 the expectation of life for a man was forty-four years. It is now sixty-one years. In the case of a woman the expectation of life has gone up from forty-seven years in 1900, to sixty-seven years now. This is due to improvements in environment and to general medical progress.

Fewer old people have anyone to look after them. Even if the person could afford a companion or a nurse, it is quite impossible to obtain one. Many members of families who used to devote their lives to the care of elderly relatives are now at work. There is a shortage of facilities for the care of the aged.

In the past, Public Assistance Institutions were the only official "homes" for the homeless elderly. These were large buildings, erected under the Poor Law Act of 1834. Many looked charming from the outside,

but inside there were large massive wards, narrow stone staircases, and no real comfort. There were many tiresome rules. Despite these appalling conditions the people who administered the institution did a fine job. The nurses looked after their charges well, and there were many very good masters of the institutions. The old people had food, a bed to sleep in, and nursing care.

In 1929, the Local Government Act placed the hsopitals under the Public Health Department. This often led to the hospital developing into places where only the acute cases were admitted, and there was no place for the old and chronic cases. Old people who might have been rehabilitated were left for more interesting cases by the voluntary hospital. The Medical Profession has been dull in waking up to the responsibilities towards old people, and the chronic sick, and means of help have not been developed.

The fear of poverty has largely disappeared. Old Age Pensions, and supplementary pensions have removed that fear, although life is still austere on the amount allowed.

Until recently the only alternative has been the Poor Law Institution of the official type. There were some exceptions, for example, Glasgow built about two hundred and fifty flats, The Crookston Cottage homes, and in Surrey all institutions were to have been rebuilt, but the war interfered with progress. One, that at Farnham, has been completed.

However, an enormous amount can be achieved without rebuilding. There are many large houses, unsuitable for private dwellings, which can be utilized for old people. Places accommodating not more than forty people are best. The ideal number is about thirty, but below twenty-five is uneconomic. Large places become institutional, and have too many rules. There is an advantage in being in the town. Country places don't work for the majority. Old people like to visit friends, go to public houses and pictures, or even just to sit in a window where they can watch others doing these things. Although accommodation provided in the country may be convenient, many people accustomed to living in a town, would rather remain in town. As many as possible should be given single rooms. The people should be allowed to bring their own furniture. It is not so cold and impersonal to them, but bringing beds may be impractical. If the home is for both sexes, it is a great advantage to have a room where the men can be by themselves. There should be one common room meal a day. This not only assures one good meal, but gives an opportunity to observe whether the person is well or not without visiting rooms. There should be no rules.

Elderly people in these homes, should be allowed to lead a perfectly normal life. If they are near a park, they may like to visit it, and relatives should be permitted to visit at any time. There is no point in coddling.

Houses utilized may need structural alterations. The staircase should have a hand rail both sides, and easy straight stairs. There should be good stair carpet, and good lighting on the stairs. (10% of fatal accidents to people over sixty occur on the stairs). There should be either a hand chain or rail for the bath. Shelves and meters should

be low, to prevent climbing on chairs. Fires should be guarded. There is a tendency to think that gas and electric fires are not so dangerous as coal fires.

It must be remembered that old people are getting older. As time goes on this makes many new problems. Those who need it, must have somewhere where they can get nursing attendance. The elderly get stiff joints, and may need help in getting upstairs or putting on coats.

If it becomes necessary for hospital treatment, they should not be sent to special hospitals. They must be sent to general hospitals. The best medical attention must be available. However, separate wards may be used. Most of the chronic sick people are past sixty years of age, but they respond well to treatment. Of the total admissions of elderly people based on information from four hsopitals, forty per cent will be able to go home in six months; forty per cent will die, because they have an incurable disease; and twenty per cent will remain chronic sick. This paints a promising picture of freeing hospital beds, and improvement may be possible. Young people are needed for this work.

Health Visiting will be expanded to looking after the whole family welfare, generally. This will include all people in the Health Visitor's area, including the elderly. By early recognition of ailments, earlier treatment can be obtained, and chronic conditions prevented from developing.

Under the new Health Act, there will be, unfortunately, a different authority for the sick and the healthy aged. It is important to arrange for easy entry and exit to hospitals for the old people. The old poor-law infirmary must not be recreated because hospital authorities are not willing to admit old poeple to hospital. Many old people do not like going into hospital, because they feel they are losing their privacy and personality and are sure to die. There must be a two-way traffic—old people entering hospital, and old people coming out cured or improved.

The possibility of building new homes and hospitals at present is not good, but much can be achieved by the intelligent use of kindness, paint, and flowers.

MENDING BROKEN HOMES

MRS. ESTHER WATSON.

THE PROBLEM.

In 1945 the numger of mothers convicted of neglecting their children was 1182. Of this number 558 were sent to prison. Prison remedies nothing. While the mother is in prison her children lack a normal, stable home life. They may be boarded out and feel that their mother has forgotten them; they may be handed to the cold paternalism of an institution, a poor substitute for even the roughest home. When the mother returns from prison and starts the home again the neighbours know all about her and she returns to an atmosphere of watchful suspicion which reacts on her treatment of home and children.

ITS CAUSES.

Four factors chiefly cause mothers to neglect their children:—

(a) POOR HOUSING. Many of these mothers come from houses

which are overcrowded, in which the water supply is highly inconvenient more mothers are convicted for uncleanly neglect of their children than on any other single charge—in which the sanitation is disgraceful.

(b) POOR EDUCATION. At School children begin their housewifery course too young and have forgotten most when they most need to remember. The housewifery course should come at the end of the school life. Thus many young women start married life knowing little about keeping a home and realising little about the true and real responsibilities of married life. And many of the older generation of mothers, who have gained this knowledge from their own parents, fail to pass it on to their daughters who thus start their married life more ignorant than their mothers were. Further, women convicted often plead poverty, but when the plea is examined poverty turns out to be ignorance. Money is not lacking, but rather the knowledge of how to spend that money to the best advantage.

(c) HEREDITY: many of the convicted mothers are either mentally deficient or nearly so, many have poor physique, many are born muddlers.

(d) MORAL DEFECTS: some convicted mothers have nothing wrong with their intellects nor with their circumstances. They are selfish and too much concerned with their own pleasure to trouble to look after their children. This kind needs a change of heart.

THE REMEDY.

These mothers convicted of neglecting their own children need not imprisonment but training, and to supply this training is the aim of the Elizabeth Fry Training Scheme. A house, "Little Pond House", in Tilford near Farnham, Surrey, has been lent to the committee. Here with the keen approval of the Home Office, the scheme of training will begin. The mother convicted of neglect will voluntarily be put on probation with the condition of living in Little Pond House for four or five months and there receiving such training as will fit her to look properly after her home and children. She will be trained in housewifery, child management, cookery, the proper spending of money, the values of food. She and the others will do the work of the house under conditions which will roughly approximate to those in her own home. She will have with her her own children under five, so that she may look after them herself and may watch and note their improvement. Visits from her husband with the older children will be welcome as reconstituting for a time their home. At the end of her training period she will return home able through practical experience to cope with the difficulties which formerly overwhelmed her.

This plan for training will begin in a small way, as it is frankly an experiment. Six mothers and their children will be accommodated at a time under the general care of the warden and his wife who themselves have two children. The wardens will be helped by an assistant warden and by a children's nurse. If this experiment proves its value over a probationary period the Home Office will encourage the setting up of similar training centres in other parts of the country and will help financially.

Prison provides no remedy; training does.

The Young Family

ANTE NATAL CARE

Miss G. Hill.

I see that the slogan for the Summer School is "A Healthy Family for a Healthy Nation." That of course is, in general terms, the aim of ante natal care. We are out to secure, that a healthy woman maintains her health during pregnancy, has a normal physiological labour, is well and healthy afterwards, and produces a healthy living child.

I now wish to discuss with you the way in which we endeavour to attain this end, and begin by outlining how I personally think that ante natal care should be carried out.

First I would like to suggest what the medical side of ante natal care consists of, and second, how it should be carried out.

1. **General appearance.** Dimensions, and physical development of patients.

2. **History**:
   (a) A special reference to T.B. in the family.
   (b) previous health—asking about Scarlet Fever. Rheumatic Fever, Diphtheria, operations or any other serious illness.
   (c) Obstetric history.
   (d) Menstrual history.
   (c) Health during pregnancy.

3. **General Examination.**
   (a) General physique and build, height and weight—size and type of shoes.
   (b) Heart.
   (c) Septic foci.
   (d) Veins.

4. **Accessory Investigations.**
   (a) B.6.
   (b) Urine.
   (c) H.C.
   (d) Rh. factor.
   (e) W.R.

5. **Special examination in regard to pregnancy**:—
   Breasts, abdomen, pelvis, measurements, X-Ray, Internal examination.(?)

6. **Advice** re clothing, rest, exercise, and general hygiene, including bowel training, diet, and special services.

7. **Arrangements for Delivery.**

8. **Further Visits** at intervals, for urine testing, Blood pressure, and abdominal examination where necessary.

How should this be carried out?

Team work by Midwife, Doctor and Health Visitor.

A regular appointment system, and the following up of defaulters.

Personal contact is very important, and the ante natal care must be carried out by the team who will conduct the confinement, and continue with the Child Welfare afterwards.

Patients must be taught the art of Relaxation, and the conduct of delivery should be explained to them. This will inhibit the fear complex and make their labour easier.

None of us yet know what the future of the Medical Services will be, but if we can get for our patients a greater continuity in the care which is exercised, with full facilities for all possible eventualities, and moreover that this care, and these facilities be readily available in every locality, we shall have taken one step further towards achieving The Healthy Family.

INFANT FEEDING

DR. D. MCCARTHY.

WITH SPECIAL REFERENCE TO BREAST FEEDING.

Rules for the feeding of healthy infants have evolved through long experience, on the principle of what is best for both mother and child.

In the 18th century, B.F. continued until the second year, or until complete dentition. Length of period was gradually reduced, and now there is considerable failure in B.F. at all.

Modern rules consist in giving:—

a. Colostrum and complimentary feeds first few days.
g. Breast, 3 hourly, or 4 hourly from birth.
c. One breast for each feed, if possible.
d. feeding time 20 mins. or less.
e. amount of feed allowed at rate of $2\frac{1}{2}$ oz. per lb. baby weight.
f. Weight increase approved 6 oz. weekly (12 oz. permitted).

MORE NATURAL METHODS.

In primitive countries, babies are fed as needs demand, e.g. when hungry, or when mother feels tension in breast. Recent experiments were carried out in America on a "self-demand" regime. Babies were not fed by the clock, but when they cried hungrily, and were allowed to stay at the breast as long as they wished. A graph of twins showed that whereas the baby in the first few weeks was fed both two hourly and six hourly in the same 24 hours, it rapidly reduced its feeds to only three daily. (Four feeds per day during 3rd month and three per day by 4th month).

RULES FOR ARTIFICIAL FEEDING

(a) Attempt to humanise cow's milk.
(b) Train baby to digest milk like a calf.
(c) Milk must be cooked.
(d) Careful balance of proteins, fats and carbohydrates.

(e) Sugar important.
(f) Danger of overfeeding with full cream dried milks.

It is an error to think that cow's milk can ever be humanised. Humanised milks which are used in the early days of artificial feeding, should not be used too long, as baby becomes underfed in protein and overfed in bulk. A baby quickly learns how to digest cow's milk. There is a tendency to overfeed, as it is often forgotten that 1 measure of dried milk to 1 ounce of water=whole milk, and very young babies cannot always take whole cow's milk.

A baby may take H.C. milk quite well, but after taking F.C. milk at full strength over a period, intestinal disturbances may fellow through an accumulation of fats.

Artificial feeding is often blamed for sore buttocks. It is not the food, but the balance which is incorrect. The commonest cause is *lack* of sugar, though excess can cause intestinal fermentation, and acid stool. (A strongly alkaline stool can also cause sore buttocks). A 6/12 old baby taking in 1¾ pints of milk a day may be taking in too much fat. This favours the production of ammonised urine leading, to a profuse burning of the skin, with superficial blisters if napkins are not changed as soon as wet.

Do present rules for Breast feeding really help its performance and continuation?

Recent Decline in Breast Feeding. (Public Health Report 91. 1943)

80% Breast fed on leaving hospital } 50% after 3/12 } 40% after 6/12
95% Breast fed on district when midwife leaves. }

It is difficult to get statistics, but probably the maximal falling off is in the 6th week or earlier.

Environmental factors recently shown to influence Breast Feeding

Highest degree breast feeding is among better classes.
Adequate attendance at Ante-Natal Clinic.
Presence of specialist at Ante-Natal clinic.
Age of mother. (The older the mother the higher incidence of Breast Feeding).
Crowding of home—reduction in breast feeding.

Maternal Causes

Physiological (a) inadequate secreting tissue in breast.
Psychological (b) secondary to the effects of cracked or depressed nipples, or high milk tension over a period.

Other indirect causes are—

(a) Illegitimate pregnancy.
(b) Cosmetic (breast feeding impairs shape of bust).
(c) Discomfort.
(d) Low intelligence.

Some answers given by mothers to the question—"Why did you cease to breast feed your baby?"

(a) Doctor's Advice.
(b) Illness of mother (usually in puerperium).
(c) Baby lost weight in first three or four weeks.
(d) Milk failed—usually about four weeks.
(e) Cracked nipples—birth to five weeks.

But during a recent survey on the reasons for introducing artificial feeding, about half the mothers gave the reason that the milk had failed.

The Infant and Mother in Hospital

The lowest percentage of breast feeding, is among women who were confined in hospital. Could this be due to

(a) Separation of mother and child.
(b) Lack of rest.
(c) Lack of privacy.
(d) Fixed feeding times as opposed to feeding on demand of infant.
(e) Complementary feeds.
(f) Test weighing leading to loss of confidence of baby, mother, staff.

Could "Self Demand" or "free feeding" be the answer?

THE YOUNG CHILD

Miss K. Davey

The ordinary child of three years comes to school in a very good state of health. He is happy and eager. The same is true of the five year old just starting school who comes from a good home. These children have been under the supervision of the Infant Welfare Clinics and health visitors.

If the mother is reluctant about sending the child to school he will jave a difficult time settling in. Sometimes a child of even six and a half years has never been to school before, this is rare but frequently children well over five years come for the first time. This may, of course, be due to illness, but the mother may have just kept him at home to look after younger brothers or sisters. He has probably heard awful tales about what will happen to him at school. These are usually the children with teeth and vision needing treatment. These too, are the children whose mothers say that they don't wish their children to be treated at the school dental clinic. They usually say they will have private treatment and then try to avoid treatment. These children are often backward in every way, and have had little social training.

In contrast the three year old is eager to try everything and likes physical exercise. He is noisy too. The school must make provision for all his needs. The five year old is very self-reliant, and his speech is good.

The three year olds should come into a room prepared for them. They like water play, play with dough, painting, doll play, building with bricks, and they like to help the teacher with the flowers. Children are out of doors whenever possible, they may play in or out as they

wish, all doors are open. They work with all sorts of apparatus. The children are trained to put their things away when they are finished with and keep cupboards tidy. They set the tables for milk and move chairs for a "morning ring" when they sing and talk with the teacher.

They water the garden, play in the sand pit, or on the jungle gym, trolleys, slides, boxes, nesting bridges, and other apparatus.

One by one, they wash, do their hair, and prepare for their meal. They then take a picture book, or sing until the food is on the table. Their appetites are usually good, but sometimes there is difficulty with cabbage. They all try a little, and are given an interest in their food. Small helpings are given followed up by "seconds," and even "thirds." The children help clear away, and then prepare for their afternoon sleep.

Many mothers say their child won't sleep, but usually this is not so. After about an hour they begin to awaken and get up. Those who are still asleep are not wakened until the last. Many mothers who have said their children would not sleep in the afternoon, report that their children are better tempered in the evening now that they have an afternoon sleep. The children help to fold blankets and put the beds away before going out into the garden, or listening to music or story.

The five year olds just starting school have just the same treatment. They are free to choose their own occupations but of course their apparatus is suited to their needs. They are free for the first part of the morning. After about an hour they have their morning ring and then use apparatus with an approach to general school work.

With the six and a half year olds, it is found, that although they too are free to choose occupations they do not settle down so easily for a while. They are, at first, put in with children who are free to choose apparatus and work in the garden. There is a free programme and lost of music. After a time they can be put with children of their own age.

There is close co-operation with the School Medical Service and the standard of health is very good. The nurse visits daily if possible. After a few days, the new child stops associating the nurse with pain, and gets used to the idea that she will not hurt him, and find Nurse is a friend. All have their throats sprayed daily with glycerine and thymol—teachers too. The Doctor visits every two weeks and when necessary. Each child is medically examined every three months or more often.

There is a high standard of cleanliness. When a new child comes, the mother is introduced to the teacher, and she is told what is expected of her. The child is excluded if the condition of the hair is not satisfactory, and the hair is considered unsatisfactory if there is only one nit. This saves greater trouble both to the school and to the mother.

The head teacher tries to find out something of the home conditions. The nurse visits the home and she and the head teacher exchange knowledge. When the child has settled in the mother is invited to spend a day in the class room. She can hear how the teacher speaks to her child, and the child feels the teacher and mother are friends. The teacher learns a lot about the mother by this individual talking.

The dentist visits once in three months. A list is kept of the mothers who refuse treatment. Later if the child has toothache the mother is reminded by the dentist, that she should have had treatment before.

The school has a long waiting list. Some children are given priority on the recommendation of the doctors or the Infant Welfare Authorities. If a child lives upstairs and has no place to play, his case is given special consideration, as these children are even more handicapped than children from large families and poor homes. Only the child's welfare is considered. In the school there are a few children of professional parents and some of trades people. All the children look the same in the class-room. This is another advantage gained by the mother spending a day in the class-room. She will see if her child doesn't look as nice as the others and the teacher can give individual help and advice.

The school takes children from three years of age until seven plus years of age. The children progress better if they are free, but the freedom is orderly. Unfortunately, classes of over fives are too big and the teachers handicapped.

The school aims at helping the mother to fulfill her responsibilities, not to relieve her of them and aims at great co-operation between the medical and teaching staffs.

PUBLIC HEALTH CARE OF THE CHILD SUFFERING FROM CEREBRAL PALSY

(Little's Disease; Spastic Paralysis)

Sometimes known as Spastic Parraplegia, di-or monoplegue Athetosis; Ataxia

Dr. J. L. Burn

The child suffering from cerebral palsy is the most neglected of handicapped children. Yet much can now be done for these children. There are some thousands of educable "spastics," as they are usually called, and it is up to us to redress the wrong by providing full services, preventive, curative, educational, vocational and psychological.

Some 30% of these children are mentally defective, but as a group they are not "hopeless idiots to be put away and forgotten."

A few surveys have been carried out. In my area there are 42 out of 38,340 children between the ages of 0-15, an incidence of 1.1. per 1,000. We have failed to make diagnosis sufficiently early; consequently there is a different incidence of the under fives and over fives.

In Glasgow in 1946, careful investigation showed that there were 234 school children in 168,000 suffering from cerebral palsy, suggesting an average incidence of 12 cerebral palsied children per 10,000 school children. In America, Phelps suggests, from careful surveys, that "seven children suffering from cerebral palsy are born each year in every hundred thousand population," of these one dies in infancy and two are ineducable.

There are three rules in public health care of handicapped children. The first is prevention; the second is prevention; and the third is prevention! We must lessen birth injuries, obstetrical violence, test for the rhesus factor. Reduction can be made in the small proportion of

cases due to causes such as whooping cough and injuries (falls) leading to subdural haematomae. It is all-important to make an early and accurate diagnosis—the latter often a difficult matter for the neurologist. The younger the infant, the earlier appropriate treatment, there is less to unlearn, and the faster progress. Promising results are claimed by American neurol surgeons in the tapping of subdural haematomae within the first weeks and months of life with a lessening of pressure on the brain.

Team work is absolutely essential in treatment. Included in a team are the child welfare and school medical officer, neurologist, orthopaedic specialist, phsyiotherapist, psychologist, speech therapist, occupational therapist, child guidance expert, health visitor, school nurse, almoner, teacher, and last but certainly not least, the parent.

So many of these children have multiple handicaps; paralysis, speech defects, epilepsy and/or psychological disorders.

A number of new drugs, for example tubo-curarine, are being tried out in selected cases; but there is no easy cure-all.

Active exercises and relaxation in specially trained hands are useful for babies and toddlers. Parents are taught to co-operate with simple home exercises, and are impressed that something can be done.

In one area a comprehensive register has been compiled of the names and particulars of children suffering from cerebral palsy, recording the degree of spasticity and mental abilities, and enabling a full review to be made periodically. This enables an answer to the recurring question, "are we doing all that is possible for these children?"

EDUCATION

Nothing must stand in the way of an educable spastic or athetoid receiving all the educational instruction it can, so that the child may be fitted for work and for life. In America many spastics have reached good positions, are happy, and are doing useful jobs. Their numbers include doctors, lawyers and many other professional men.

Statistics compiled by the pioneer worker Winthrop M. Phelps (of seven children suffering from cerebral palsy born each year in every hundred thousand population, one dies in infancy, leaving six per hundred thousand, of which one-third will be feeble-minded, the remaining two-thirds being capable of education and training to various degrees of efficiency) give about seven hundred "educable" cerebral palsy cases under the age of sixteen in every million population. Phelps offers living proof that these children are worth salvaging. His work has led to the founding of the Children's Rehabilitation Institute, a residential school for children suffering from cerebral palsy, near Baltimore, U.S.A. The Institute provides accommodation for 80 children, who are admitted in the first place for a trial period of 3 months to ascertain whether on not they would benefit from a longer stay.

A pioneer centre was set up by the L.C.C. at Queen Mary's Hospital for Children, Carshalton about three years ago. It is linked with the School Health Services and has a team of consultants in addition to a staff which includes physiotherapists, an occupational therapist and special school teachers. After a full examination to discover the abilities

of each child, the physiotherapy exercises are prescribed. Training is also given in speech and feeding. An endeavour is made to treat the whole personality of the child.

A recent visit showed excellent work done in this pioneer unit. The improvement in the co-ordination of movements of the children at meal times, over a period of months, was remarkable. A fine team of specialists is available.

St. Margaret's School for Spastics, recently opened at Croydon, is also doing fine work on similar lines. At present incontinent and mentally defective cases are not accepted.

At a training school, at St. Loyes, Exeter, vocational guidance and training is given.

It must be remembered that most, if not all, the children at these centres would have had little chance to have had any training or education. There is urgent need for their extension.

In my own area a small day school for 'spastics' who had been previously excluded from ordinary school has been established at the Municipal Hospital. Accommodation for eight children has been found, to form part of the hospital school. The pupils are brought from their homes daily by ambulance. Not one case has failed to benefit.

PSYCHOLOGY

Parents and others dealing with these children need to remember that they are not sick or in need of coddling. Sympathy must take the form of encouragement to self-help. Each child is a unique individual, fighting his own battle to overcome his disability, and feels all the urgent needs common to all growing children. Not the least of these is the need of love and the sense of security love gives. The defect has often already given a sense of inferiority. A link with the Child Guidance Service is needed to help in some emotional difficulties, etc., but eventually a good job is the best therapy. Dr. Earl Carlson, himself a sufferer from cerebral palsy, who has overcome his disability, has said, "The turning point in my life was the day when I saw there was something to do."

The care of these children is based on the same principles that can be applied in the case of children suffering from other handicaps—early ascertainment, the younger the child the better; close co-operation with and training of the parents in better home care; adequate educational facilities and emphasis on the needs of the whole child as well as on the best physical care. For all handicapped children, these principles form a solid basis of hope for a finer and fuller life.

MAKING THE CROOKED STRAIGHT

Miss L. Billinghurst

Faulty binocular vision means the failure of both eyes to work co-ordinately together. In the treatment, the Health Visitor and the School Nurse can be a great help.

Orthoptic treatment consists of a re-education of the brain to make both eyes work together, and is not, as is popularly supposed, merely

a series of eye muscle exercises. Owing to the cerebral nature of the visual processes, training the binocular functions to develop correctly in those whose binocular vision has been upset by muscular pausis or refractive error, is not a passive treatment, but requires much mental effort and perseverance on the part of the patient, as well as much patience and ingenuity on the part of the Orthoptist. Orthoptic treatment can be given to any child over the age of four years, but a child is never too young to be under observation if a squint is noticed. Even if the child is under twelve months of age, and the squint is only occasional, an ophthalmoligist should be consulted. So much can be done to prevent a squint getting worse during the formative years. It may be possible if treatment is started early enough, to cure the defect without more elaborate treatment.

If the squint has been present for six months, the eye specialist usually prescribes the covering of the "good eye" with an occluder, until the vision of the "bad eye" improves. This occluder may have to be worn constantly. It is here that the Health Visitor or School Nurse can help by explaining this to the mother. If treatment is started early enough, a cure may be effected before the child must attend school, and so the child will be saved having to wear an occluder at school.

Even with the older child, hope is not lost. With the adolescent, the process of cure may require a longer time, but no age limit can be placed on the prospects of recovery.

Up until the age of seven years, with a very few exceptions every child is long sighted. In the case of pausis of one of the muscles of the eye the wearing of glasses alone may not correct the squint, and an operation may be necessary. Modern specialists are inclined to operate on children at a much earlier age, even as young as eighteen months. The child will then have a better chance to develop its binocular reflexes correctly. The brain will more easily be able to learn to use both eyes properly. Early operations prevent psychological difficulties, caused by squint.

An instrument called the Synoptophere is the one used chiefly for training binocular vision. With this instrument the patient views two separate pictures, one with his right eye, and the other with his left. When the instrument is adjusted to his angle of squint, he should see the two pictures as one composite whole. This is usually difficult for him to do if he has faulty binocular vision, as he has to learn to fuse, in his brain, the image received by each eye. When he has learned to do this at his angle of squint, then he is ready to undergo an operation for putting his eyes in the parallel position. When this has been done he is taught how to read with both eyes together, and how to use his eyes together in his daily life, which of course was impossible for him to do while he had a gross angle of squint. There are certain types of squints, which do not require an operation and can be controlled by the patient when he has learned to use his eyes together correctly.

In the case of a child, if constant occlusion of one eye is prescribed, an adhesive plaster patch worn on the face is the most effective. Under no circumstances should the child be allowed to "peep." If the vision is much lower in the squinting eye, the child must be given every in-

centive to use that eye, and must be encouraged to see detailed pictures, tell the time on the clock, and trace intricate designs. (These are naturally only suitable for older children with Amblyopia ex Anopsia, as this type of "blindness" is called). Great care should be taken of a child of any age who wears an occluder, while playing in the street. However, the child must be treated as normally as possible at other times.

Much time and trouble could be saved if all children with squints were treated properly in the early stages of their defect. It is much more difficult, although not impossible, for a child over eight years of age to recover his sight in the squinting eye, than it is for a younger child. Every effort should be made on the part of the Health Visitor and School Nurse to persuade the parent to insist on the young child wearing an occluder if prescribed. These need not be unsightly, and can be made of flesh coloured adhesive or other material.

Most important is the attitude of parent and neighbours, Health Visitor and School Teacher, towards the squinting child. Most children with squints develop a shy awkward manner, or are over aggressive; due to their inferiority complex. This is due to the attitude of their school fellows and others to their often unsightly appearance. It is a great handicap when people do not look you "straight in the eye" when talking to you. Many a patient has been known to remark that one of the greatest advantages of learning how to straighten his eyes, has been that he can look people straight in the eye, and get a steady and unembarassed look in return. The Health Visitor should try to impress upon the parents the importance of not discussing their child's defect in front of him, or allowing anyone else to do so either. He must be treated like a normal child.

General

THE SOCIAL PROBLEM OF TUBERCULOSIS

AIR COMMODORE R. R. TRAIL, M.C.

The history in advances in the treatment of Pulmonary T.B. is the history of the aspect of the disease especially emphasised in each decade. In the early days of Sanatorium treatment, emphasis was placed on the Public Health aspect. Once after-histories of sanatorium treatment began to appear, emphasis shifted to treatment of the individual. Now that artificial pnuemathorax, with its accessories and specialised surgical operations have been perfected to a stage when most cases which are unilateral on diagnosis can expect an almost certain arrest of the disease, attention is being paid to the aspect of Bacterial Infection. We are in the age of research for chemical and biological synthetics, by which it is hoped to eradicate the T.B. bacillus. The specific when found, will not prevent the onset of the disease; it can only hope to cure an established lesion. Early diagnosis and efficient treatment do not remove basic and causative social factors.

For more than a generation we have realised that phthisis is a disease of the soil as well as of the seed. We no longer stress the factor of heredity. We admit the dangers of massive infection, and the necessity for proper contact examinations, and are increasing our efforts in X-ray diagnosis and dispensary observation to combat them, but we are still doing far too little to deal with environmental factors which are continuing prime causes in the appearance and development of the disease.

Great Britain is spending £12,000,000 per year on Tuberculosis, and for this we are getting little beyond Sanatorium treatment. The Sanatorium has its own place in the scheme of treatment, but it is necessary to consider it in its true relation to our problem of the social aspect of the disease. The Sanatorium is a good middle part of treatment badly let down by faulty supports at both ends. These are:—

1. the material with which the sanatorium is provided.
2. the conditions to which its ex-patients must return.

The functions of sanatorium treatment are often decried, and critics do not realise that the results are due to the limits placed, through no fault of its own, to the possible benefits the Sanatorium can confer. It is true that of patients discharged from L.C.C. Institutions in 1932, 60% of the moderately advanced, and 90% of the advanced cases were dead within five years, and most of them within two years. We must not forget however, that every publication on mortality after Sanatorium treatment, has shown that mortality is in direct proportion to the extent of the disease on admission. Add to this the sad fact that at a conservative estimate 80% of Sanatorium patients to-day are in stage two or three on admission.

Mass radiography is certainly a gain in diagnostic procedure, for, properly used, it is the first step towards the discovery of unsuspected but active disease. If this is to act as the first stage towards efficient treatment, it will require more beds than are at present available, and if it is to take its proper place in prevention by controlling large numbers of previously unknown sources of massive infection, it must demand increased Dispensary staffs, particularly T.B. Health Visitors. The T.B. Health Visitor should hold the Certificate of the Tuberculosis Association as well as the Health Visitor's certificate, if possible. We need more continuity of contact between the Nurse Visitor and the patient. Almoners dealing with Tuberculosis under the new Act, should be required to specialise in, and give their whole time to Tuberculosis. Only then can we see the necessary integration between prevention, treatment and after-care; and only then can rehabilitation and after-care really achieve their proper results.

The introduction of the new Health Act and the increase in Mass Radiography have come at a time when we have a lessening number of institutional beds owing to lack of staff, both domestic and nursing. There is, however, another factor to be faced in the near future. Special training, visiting and nursing of special diseases will have to be recognised by proper monetary incentives. The Rushcliffe Scale is certainly an advance, but it must recognise by higher pay, the special sacrifices and qualifications necessary for those who visit and tend the tuberculous sick.

We are left in a vicious circle so far as Sanatorium accommodation is concerned. The occupation of beds by patients with advanced disease is preventing us from doing our duty by the early case now discovered through intensive contact and X-ray investigations. The Sanatorium has always had two duties, and if we concentrate on its duty to the community in respect of prevention through segregation, we shall forget its duty to the individual. Every advanced case was once an early one. The dying case occupies a bed for the same length of time as it takes to bring about arrest in three early cases, or restored working capacity through efficient rehabilitation in two moderately advanced cases. It is no exaggeration to say that the man with advanced disease who lingers on as an ambulent patient for ten years in an institution, denies the possibility of rehabilitation to forty of his fellows.

What of the second limit we are placing on the Sanatorium? Before his discharge, the patient is given advice on his future. That he can very seldom carry out such advice because of its economic implications is not the fault of the patient, and certainly not the fault of the sanatorium.

The two main fundamentals of medicine are to listen carefully to the patient's story, and to examine the whole patient. If we cannot give time to study the details of the patients' past in his work, and its suitability to his temperament; to his relations with his employer and fellow workers; his family difficulties and their economics; his leisure and spiritual outlook, we have no authority to outline his future. It is not sufficient to listen to his chest, take X-rays, to send samples of blood and sputum to the laboratory, and write up pulse and temperature records.

Unless we study him as a man who has disease, we may reach an expert summation of the damage to his lungs, but we shall never know the primary causes of his breakdown and therefore know how to alleviate or remove them. It is valueless to advise him about good food, fresh air, and leisure. He can never have leisure without economic security, and can seldom reach the state of mental peace which our advice usually implies. Moreover, such advice all too often envisages a future which is fixed and immovable, and lays undue emphasis on the continuance of rest.

We all know the value of rest in the treatment of phthisis, but very seldom is it explained to the average patient, that while bodily and mental rest is the basis of all treatment for an active lesion, to be carried out for a period that varies according to the needs of the individual, such rest must be followed through increasing activity up to the full amount possible for the physical disability, if the patient is to have increasing vitality. No man can afford to consider work a crime. Neither loafing in a Sanatorium, nor drifting laziness on his return home will give a man back his self-respect, or fit him to take his true place again in the life of the family and community, where alone he will attain the freedom and completeness of personality which change mere existence into life.

An ex-patients return to the community is not easy, as he always has to face a certain amount of ostracism. He usually looks well, with the overhealthy tan of the Tuberculous, who have lived for some months in the open air conditions of the Sanatorium, so he will get little sympathy. His former friends will often shun him, and the average employer will be unwilling to have him back because of his tendency to winter bronchitis, or actual breakdown, and other workers may refuse to work alongside him. This is why so many ex-patients have a recurrence of the disease. Not only do they have the worry of loss of friendship, and difficulty of finding their way back to their own trade, but very often they have to take on unsuitable jobs at badly paid rates, and can get even this, only by becoming a social, hiding their disease, and thereby becoming highly dangerous to their contacts.

We see therefore, that very often, the return to ordinary conditions adds new psychological and physical difficulties to those which produced the development of the disease in the first place.

Mass radiography shows that in the age groups 17-24 and 35-39 there are large numbers with evidence of fresh lesions and no evidence of previous lung involvement. In the earlier group we find a large number of psychological difficulties, *e.g.* problems of leaving home, of starting of work dictated by necessity and not by choice, disappointment over love affairs, of the sudden realisation that life seldom provides the easy road to success. It is probable that we see here, why the incidence of tuberculosis in adolescents has never fallen in conjunction with the general fall experienced over the last fifty years, and in particular, why the incidence in young women shows less improvements than that in young men.

In the 35-39 group, we often find that economic difficulties produced a psychological stress that eventually brings a breaking point, *e.g.* drag

of weekly house payments, worry about the children's education, bus queues, straphanging at the beginning and end of each day, frustration at work, and fears for economic security in old age. Recognition of these factors has led of late to attention to the Psychology of Tuberculosis, and the help of the neuro-psychiatrist is sought. immediately the patient gets past the acute stage of his illness. The Social Worker and Health Visitor should provide the Sanatorium physician with details of the previous standard of life, which must be maintained if the patient is to get the best advantage from his residential treatment.

I believe that all these attempts, praiseworthy as they may be, will fail if they are set up as a substitute for, and not a complement to religion. I believe that an understanding minister of religion can be of enormous help to the patient, his doctors and his nurses. He helps to attain the human end of treatment, which is something beyond the physical treatment of the most up-to-date technical operations.

To bring back the former status to the tuberculous, must imply restoration that is psychological, economic, and social, and it is hoped, that under the new Health Act, such a comprehensive scheme will develop in every region in the country. The first necessity is a Reception Centre, a Hospital Surgical Block, where every investigation made on the patient through the Dispensary, Social Worker, and Health Visitor, is available to the Physician-in-Charge, so he can make an appropriate decision for each individual sufferer.

By physical treatment alone, a fortunate few will be able to return to their former work, and to their homes and so can command the full wages he had before the breakdown. Some will remain so reduced in their capacity, that they are either completely bedridden, or unfit for work outside their own homes. The majority will be of the chronic type, liable to be infectious from time to time and for the rest of their lives, but able to work after training in sheltered conditions for varying hour per day. For this latter group it may now be possible, under the new Health Act, and by close co-operation between the Ministry of Health and the Ministry of Labour, to do more than we can at present.

The first attempt to establish a Village Settlement was made by Sir Pendrill Varrier-Jones, in 1915. He recognised that what was needed for the Tuberculous was continued care—not after-care, begun on the day of admission, and carried on as long as necessary to the requirements of the individual patient. He therefore built his settlement round the Hospital. Sanatorium and Surgical blocks, so that from them the patient could graduate to slowly increased hours of work, and to them he returns whenever he needed further treatment. The idea behind such a settlement, is that rehabilitation should take place during, and remain an integral part of treatment.

A scheme is required which will allow an ex-patient to enter a rehabilitation Centre as a "patient-worker," drawing full allowances for his family while he is learning a new job.

This would integrate the work of the Ministries of Health, Social Security and Labour under the new Act, because the Ministry of Health would be responsible for the cost of such treatment as the patient-worker still requires, while the Ministry of Social Security would see to the

maintainance of his family, and the Ministry of Labour would provide the workshop training. By such a scheme the patient could be fitted for work in a Remploy Factory near his home, or in a colony to which he could bring his wife and family.

This is I believe, the only possible answer we can make at present to the social problems of Phthisis. Only by so working for the powers which appear open to us under the Health and Disabled Person's Employment Acts shall we be fulfilling our true function, which is to act as teachers and keepers of the health of the nation.

THE VALUE OF HEALTH VISITORS' RECORDS

Miss Cooper Hodgson, M.B.E.

What is the value of Health Visitors' records? It is that they are pieces of research work. We are all familiar with the wonderful results of research among drugs, *e.g.* the sulpha group and penicillin, these new substances have done marvels in the *cure* of disease. The field of our research as Health Visitors' is *prevention* of disease.

Families live in homes, not clinics or hospitals, and the health visitor enters as a friend. The nation's health has been maintained throughout the war years, it can be improved in peace time.

It is the health visitor's job to teach the laws of hygiene, and where necessary instruct the people as to statutory health benefits. Many people know of the services but will not use them, so improved propaganda is necessary. Everything concerning the home and the family affects the mental and physical health of each member of that family. In some localities, a health visitor knows the children from birth until they leave school, which means 15-16 years contact with the parents. She is also concerned with Infant Life Protection, Tuberculosis, Adoptions, Old People, etc. An experienced health visitor asks very few questions, but uses her eyes and ears.

Owing to the wide field of health visitors' duties, it is necessary to cut down writing to a minimum. This is usually done by using a code of abbreviations or numerals. In normal cases, all necessary information concerning the first five years can be contained in about 500 words, counting four abbreviation letters as one word. The records should be as concise and informative as possible as, though the person who needs them most is the health visitor herself, she may be called upon to give information at a moments notice.

Tuberculosis, school, and mental deficiency records are already fairly standardised, and I think the time has come to standardise the home visiting card for under fives. Essentials are compactness and sufficient headlines.

I am all for completing the notetaking in the home. Valuable time is lost by taking rough notes and writing up later. In all my thirty-five years as a health visitor I have rarely known anyone to object. Mothers know that these particulars are written down at clinics, hospitals and other places, and don't really think much of the health visitor who has to ask the same questions at each visit.

It is a matter for regret that health visitor's never have time for statistical work, it is a great help to be able to tabulate one's work. I think the value of health visitors' records are not sufficiently appreciated in high places. I still hope to see the Minister of Health, periodically as a matter of routine, calling in say, the cards of all 3 year olds in three industrial and three rural counties, and next year similar records from county boroughs. I suggest that retired health visitors with special clerical ability would make excellent temporary statistical workers for this purpose. The Minister would get valuable information, and we should see a general improvement of records—one learning from another.

Among important investigations based on Durham County health visitors' records may be mentioned "*Infant and Maternal Mortality*". in relation to size of family and rapidity of breeding. By Mrs. C. M, Burns, M.A. (from the Department of Physiology, King's College University of Durham). For this work Mrs. Burns studied Durham records for children 0-5, 1930-37. And "Some Fertility Rates by Age of Mother and Order of Birth," published in the "Annals of Eugenics" 1940. For this Dr. Kitty Conrad (from the Department of Epidemiology and Vital Statistics, London School of Hygiene and Tropical Medicine) used our records for the year 1931.

To sum up—we are not the only, or most important research workers, but we are in possession of the most vital field—the homes, in which about 70% of the people live. We must observe and record, so that those highly skilled workers whose time is more valuable than ours, can call for data at any time and rely on us to provide it.

GOOD DENTITION

William Ritchie Young

There is a common tendency when teeth, or dentistry, is under discussion to resort to what I call an arithmetical confusion. A confusion because the care or study of the mouth should not be confined to individual teeth, but the mouth should be regarded as a whole, and the habit when discussing oral health of considering the number of teeth is to be deplored. This is especially true when dealing with the care of children's mouths, and if persons in any way responsible for the physical and mental development of the young could be taught to avoid an arithmetical approach to the subject, and could persuade parents to consider the mouth as a functioning organ, a sounder basis for discussion or instruction would be adopted.

Disease or damage in any part of the oral cavity affects the efficiency of the organ to a greater or lesser degree, depending on the extent of the faults present, and each part of the mouth is to some extent affected by the state of health of the neighbouring tissues.

The mouth is the gateway of the alimentary system, and has the very important function of preparing the food for digestion by (a) chewing or mastication and (b) mixing saliva with the food.

If these functions are not carried out efficiently there will be, sooner or later, an injurious effect on the general health, and the efficiency of these

functions is determined by the structure of the mouth and the care with which it is maintained in a sound and healthy state.

The mouth is a chamber with openings fore and aft—the lips and the pharynx—and with a bony roof and fleshy sides and floor.

The roof consists of a hard and soft palate. The front edge of the hard palate is the tooth bearing portion of the upper jaw. The mandible, along the upper border of which the lower teeth are erupted, is the only mobile bone of the face. The side walls of the mouth are largely composed of the buccinator muscles, while the floor of the mouth is occupied largely by the tongue. The inside of the lips and mouth are covered with mucous membrane, under the surface of which are innumerable little glands. The mucous membrane over the tooth-bearing part of the jaws is particularly tough and is known as the gum.

At the back of the mouth, one on each side lie the tonsils, whose function appears to be dealing with the protective action of preventing the entrance into the body of organisms of disease.

Into this exceedingly complicated cavity the teeth are erupted in what has commonly come to be referred to as two "sets," the deciduous—or milk—teeth and the so called "permanent" set. This is another arithmetical error; all the teeth are just as old as any other part of the body. It should be realized that definite tooth formation is discernable about the forty-eighth day of intra-uterine life and that the complete set of human teeth—permanent as well as deciduous, are formed to some extent in the jaws of the newly born child.

The process of tooth development and eruption is more or less continuous from early intra-uterine life until maternity is reached. The care and maintenance of these teeth should, therefore, be equally continuous during this period if there is to be any hope of reaching adult life with a sound set of teeth.

The crown portions of all teeth are covered by a thin cap of hard substance known as enamel, while the remaining bulk consists of dentine. In the centre of the tooth is a small cavity, the pulp chamber leading by a narrow canal to emerge at the apex of the root portion.

Caries first breaches the enamel, then attacks the dentine, to finally affect the pulp or nerve, which may in turn become putrescent and discharge through the root canal into the apical space to form an abscess. This in turn may burrow to form a fistula through which the septic products of the inflammation are discharged. This condition may become chronic, so that a tooth lesion may become a little factory sending septic toxina into the blood stream.

The sounder the development of the teeth, the better will they resist the onslaught of caries. This sound development depends on heredity, eugenics and environment.

If healthy, clean mouths are to become commonplace, this will be attained not by the services of the dental profession, but by the self care of the public, and much requires to be done by educational means to bring this commendable state of oral hygiene to be more widely adopted Regular visits for dental inspection and, if necessary, treatment should be commenced at an early age. Two or three years of age is not too early. The proper eruption and positioning of the permanent teeth depends very

largely upon the retention of the deciduous teeth in a healthy state until such time as they are due to be cast off. In addition retention is essential to proper formation of the dental arches.

The correct development of these dental arches, is influenced by the hereditary factor. The jaw may be too small while the teeth are too large. The resultant overcrowding can often be considerably alleviated by juditious extractions at the proper stages of development or by more advanced orthodontic treatment.

Another common factor contributing to overcrowding is the use in infancy of a "dummy." It causes considerable lateral pressure by suction on the sides of the infants jaws. This is equally true of thumb-sucking or toe sucking. In older children lip-sucking too has the same results.

The more perfectly the jaws develop, and the more accurately the teeth erupt and occlude, the more likely are they to remain healthy. Food particles are more likely to lodge between irregular and badly articulating teeth. The best prevention of this is vigorous chewing, and finishing each meal with some form of fibrous food stuff, such as an apple. The proper use of a tooth brush is essential nowadays as an aid to keeping the mouth clean.

In brushing the teeth, what is required is a thorough, but gentle dislodgement of debris lying in and around the teeth. This should be followed by a very thorough rinsing with lots of fluid.

Should caries be found in the mouth, it is essential for the preservation of the teeth that prompt attention be paid to its eradication. This is especially true with children, as their teeth are more hollow (the pulp chamber grows smaller as the tooth ages) and the progress of caries is more rapid and disastrous.

In addition to caries, the mouth may be rendered unhealthy and inefficient by the incidence of periodental disease. This affects the soft tissues surrounding the root and neck portions of the teeth, and the margins of the gum. The cause of this condition may be systemic (as in scurvy) or more commonly local (lodging of food particles between teeth).

Like most disease elsewhere in the body, oral disease is due to the introduction of bacteria and it is essential to preserve health that the mouth be kept as clean as possible.

THE ART OF TEACHING

PROFESSOR J. W. TIBBLE

The amount of preparation required by an experienced teacher varies according to the task. At times he may need only to spend a short time in thinking over the topic, recalling what he knows of it, think about the kind of audience he will have, and how the material should be adapted to catch their interest, and meet their needs. He will probably jot down a few motes summarising what he had thought to guide him in the actual presentation. On another occasion the lecture or talk may involve working up new materials, doing a considerable

amount of fresh reading or research, and working out pretty fully in written or visual form some parts of the presentation. In either case, if it is to be successful, teaching should embody certain fundamental principles. With the experienced teacher or lecturer these principles may be implicit, not explicit. With a beginner, underlying principles need to be applied explicitly, if the lecture is to be a good one.

NATURE OF THE TEACHING SITUATION

What is the nature of the teaching situation? What is the relationship between lecturer and audience, and the subject matter or content of the lecture or lesson? Professor Adamson describes this as a triple relationship. The audience should not be regarded as passive recipients. Listening and understanding is an active process, involving not only interaction between teacher and taught, but between teacher and content and audience. The teacher exists to put the pupil in contact with something new. It is not enough for the teacher to have a sound knowledge of the subject. There are some people born with gifts which make them good teachers, but this is not common. Most teachers have to learn by trying and failing.

Education means altering people. The audience should not leave the same as they entered. Even as a result of one lecture, the audience should be slightly different. Altering peoples' daily habits is a difficult task. Think how to place the subject before the audience. The teacher must think how to make the first attack. He should then try to arrange so that his audience will feel that the changes they make are due largely to themselves.

THE LEARNING PROCESS

For successful teaching the audience must be learning. Many books have been written on this subject. It is always necessary to introduce new terms. The way must be carefully prepared for this. Professor Whitehead analyses the learning process as comprising three aspects or phases. In any act of learning these three stages are involved. These three stages should be embodied in the act of learning whether limited to one lecture or a whole course:

(1) *Romance*

This is the phase in which the interest of the audience is aroused. If the audience is already interested or concerned in the topic of the lecture, the direct approach can be used in the introduction. If not, it may be preferable to use an indirect approach, or the appeal of novelty. Visual material is useful. The question or problem approach is good, as long as the problem is a genuine one, and the lecture does help to solve it. The use of the anecdote is sometimes abused. There is a danger that the audience may remember the anecdote, but forget the point involved.

(2) *The Phase of Precision*

The second phase is the one requiring hard work. The teacher must be familiar with the psychological principles which govern remembering

and forgetting. If the teacher assumes that the audience will remember everything he tells them, he is doomed to disappointment. He should assume that his audience will forget at least fifty per cent. of all it hears within an hour, and after that the rate of forgetting proceeds until nothing is left unless the person recalls or revises. The beginner nearly always puts too much into a talk, and does not discriminate clearly enough between the essential things to be remembered, and those parts of the talk which are intended to lead up to or reinforce or illustrate the essential points. In preparing a talk, we should form the skeleton of the talk. We should make sure by various means that these points are fully emphasised and vividly presented. The rest of the talk should support them and illustrate them. The same thing must be repeated in a different way several times.

(3) *Phase of Application*

In the past the stage of precision was emphasized too much. The stage of application is the test of all the teacher has done. The talk should lead outside the lecture to life. In the case of the Health Visitor giving a lecture or talk, she should ask herself if the people are going away to do something different as a result of her talk. For informal teaching, the chairs should be arranged in a circle. Rows of seats and desks tend to make the audience shy.

USE OF VISUAL AIDS

Visual education may be used alone or supplementary to a talk. Visual aids cover a wide range, for example, a sound film is itself the whole or main part of the teaching. Where the visual aid is used only to make a single point or to provide an illustration. The blackboard is useful for presenting essential points visually in summary form. Charts range from those designed to make a simple point vivid like a poster, to one which is full of detailed information. Isotype symbols are standardized and give an exact and vivid impression. Charts are just as important in informal work as in formal work. In the middle ages all knowledge was memorized, as there were no books. Now books dominate education too much. People are being educated constantly by the poster. Poster education should be used more in the right direction. The average person learns more through his eyes than through his ears. One chart can have enough material for a forty minutes lecture. The whole thing is before the audience all the time, spread out in space. The most useful type of chart for teaching purposes is one which takes five or six essential points, and shows how they are related to each other.

Exhibition pictures are a form of education not requiring much verbal explanation. They consist of a series of pictures and diagrams which is large enough for use with a group, or for individual study. The main disadvantage is the prohibitive cost.

The film strip or slide provides a series of pictures or diagrams in a very portable form. There is a possibility that the Health Visitor of the future may carry this apparatus with her. It may be plugged into any ordinary light socket, and so may be used in any place where electricity is available. The apparatus is relatively inexpensive, about fifteen pounds. The teacher of the future will use this method of teaching

as he now uses the blackboard. The Episcope is an apparatus which is relatively cheap. The disadvantage is the loss of light due to the reflection by mirrors instead of direct light. The Epidiascope which is a combination of episcope and lantern is not portable, and it is expensive.

Films, either sound or silent, can be used effectively. Some good films do exist in the field of health education, but many more are needed. The lecturer may find the silent film more satisfactory, as he can provide his own commentary. The film, as with other visual aids, may be used by itself or supplementary to a talk.

TEACHERS PERSONALITY, SPEECH AND MANNER

It is obvious that in giving a talk or a lecture, the lecturer will be expressing his own personality, or some aspects of it, and it is desirable that he should express as much as is relevant to the teaching situation. He must adapt his normal speech, habits, and needs to the classroom or lecture room, but he should make the adaptation seem as natural and informal as is compatible with the nature of the task. Anything that seems formal, stitled, or artificial will place a barrier between teacher and audience. The lecturer should express effectively his keen interest in the audience and in teaching them. But feeling sincere, being interested, is one thing, and expressing that sincerity and interest effectively is another. This is where art comes in, because it is an art which needs practice, and cannot be acquired quickly. Speech must be slower than normal conversation, with more stress on the ending of words. Tone should be varied, and the full range of the human voice used. Tempo must be varied for emphasis. The teacher must feel natural, confident, and at ease. To enjoy teaching (this is very different from enjoying hearing oneself impress an audience) is the main thing. The teacher must acquire the external form of confidence, this soon leads to a feeling of inner confidence.

The important thing is whether, as a result of what the lecturer has said, the audience is affected in the way the lecturer intends.

Concluding Lecture

BUILDING FAMILY LIFE

DR. L. FAIRFIELD

The Health Visitor's work for the family increases in technical efficiency, but meantime what is happening to the family?

The permanent union of marriage is essential, to bring security for a young family, and satisfy emotional needs. There is a grave risk of social integration, if a family is not united.

The first necessity is Privacy. Living with relatives causes overcrowding, resulting in emotional stress, through which the children suffer. Lack of privacy causes a lowering of standards, and is a frequent cause of Juvenile delinquency.

Much of the future prosperity and happiness of the country depends on our attitude of mind towards women in industry. A mother used to live according to her husband's wage. If we want the best social system, then the mother must be in the home during the years when the child is young. The adolescent needs parental help and care also.

When a woman goes out to work and does not accept responsibility for the child, it has to go to a day or residential nursery. The children in nurseries are well looked after, but are apt to be not quite so healthy as those kept at home. There is always the risk of epidemics, and exposure to infection, and at the least, the child usually developes catarrhs, nasal or bronchial. The tie between mother and child on the physical side, is the thing on which the emotional bond is formed, and the child who lives with its mother, developes in the ordinary way, free from emotional complexes as compared with the child who is prematurely separated.

About 50% of a working mothers time is lost when she has a young child because of colds and similar illnesses or because the nursery is closed for infection. The care of a child outside its home, is expensive for the State. There is the trained staff at the nurseries, the "concealed labour," which consists of those people devoted to child care, who give their help in many ways, plus the nurses and ambulance attendants who come into the picture when the child must go into the hospital because the mother does not wish to leave work. Juvenile delinquents are often children who are misunderstood at home, and there has been a great rise in this sad state since the mothers went into industry. A mother who has worked hard all day, arriving home at 5 or 6 p.m. (which means that the child has been running round the streets 1 or 2 hours after school) has neither the time nor patience to take much interest in the child's personal problems, especially where she has the prospect of an evenings washing or housework in front of her. Gangsters and prostitutes emanate from such an environment.

The mother's first job is to support the family from within the home and the family must realise its duty to the State.

"The Family" if it is to remain an acceptable institution must consider the interests of the individuals within the family circle. It must also be a living organism which changes with its environment, *i.e.*, young people rightly expect more independence.

The family should always do what it can to support itself and not depend on the State. The tendency to live in quiet harmony and privacy with husband and baby is very strong after confinement, and that is why it is often difficult to persuade a mother to go into a convalescent home afterwards. The husband, as a father and provider should also not be interfered with unnecessarily—or may cease to be willing to make the same efforts.

The family does not always consist of only mother, father, and child, the old people have also to be provided for, but inbalance on the side of the old people should be avoided, or the young become frustrated and rebellious.

Sociological Jerry building results from an improperly balanced family. All these considerations are strictly relevant to the Health Officer's work. They are essential for the mental and spiritual well-being of a community. Her work will be largely wasted if she works in a society of which the structure is not soundly based.